



Crack cocaine in the Dublin Region

An evidence base for a crack cocaine strategy

Johnny Connolly, Sinéad Foran, Anne Marie Donovan, Ann Marie Carew, Jean Long

HRB Research Series 6

Crack cocaine in the Dublin Region An evidence base for a crack cocaine strategy

Johnny Connolly, Sinéad Foran, Anne Marie Donovan,
Ann Marie Carew, Jean Long

This publication should be cited as follows:

Connolly J, Foran S, Donovan A, Carew A and Long J (2008) *Crack cocaine in the Dublin region: an evidence base for a Dublin crack cocaine strategy*. HRB Research Series 6.
Dublin: Health Research Board.

Published by:

Health Research Board
73 Lower Baggot Street
Dublin 2
Ireland

t 353 1 234 5000

f 353 1 661 2214

e hrb@hrb.ie

w www.hrb.ie

ISSN 2009-0242

© Health Research Board 2008

Copies of this publication can be obtained from:

Database Administrator
Alcohol and Drug Research Unit
Health Research Board
Knockmaun House
42-47 Lower Mount Street
Dublin 2

t 353 1 234 5127

f 353 1 661 8567

e adru@hrb.ie

An electronic version is available at www.hrb.ie/publications

About the HRB

The Health Research Board (HRB) is the lead agency supporting and funding health research in Ireland. We also have a core role in maintaining health information systems and conducting research linked to national health priorities. Our aim is to improve people's health, build health research capacity, underpin developments in service delivery and make a significant contribution to Ireland's knowledge economy.

Our information systems

The HRB is responsible for managing five national information systems. These systems ensure that valid and reliable data are available for analysis, dissemination and service planning. Data from these systems are used to inform policy and practice in the areas of alcohol and drug use, disability and mental health.

Our research activity

The main subjects of HRB in-house research are alcohol and drug use, child health, disability and mental health. The research that we do provides evidence for changes in the approach to service delivery. It also identifies additional resources required to support people who need services for problem alcohol and drug use, mental health conditions and intellectual, physical and sensory disabilities.

The **Alcohol and Drug Research Unit** is a multi-disciplinary team of researchers and information specialists who provide objective, reliable and comparable information on the drug and alcohol situation, its consequences and responses in Ireland. The ADRU maintains two national drug-related information systems and is the Irish national focal point for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The unit also manages the National Documentation Centre on Drug Use. The ADRU disseminates research findings, information and news through its quarterly newsletter, *Drugnet Ireland*, and other publications. Through its activities, the ADRU aims to inform policy and practice in relation to problem alcohol and drug use.

The **HRB Research series** reports original research material on problem alcohol and drug use, child health, disability and mental health.

HRB Research Series publications to date

Ward M, Tedstone Doherty D and Moran R (2007) *It's good to talk: distress disclosure and psychological wellbeing*. HRB Research Series 1. Dublin: Health Research Board.

Tedstone Doherty D, Moran R, Kartalova-O'Doherty Y and Walsh D (2007) *HRB national psychological wellbeing and distress survey: baseline results*. HRB Research Series 2. Dublin: Health Research Board.

Daly A, Tedstone Doherty D and Walsh D (2007) *Re-admissions to Irish psychiatric units and hospitals 2001–2005*. HRB Research Series 3. Dublin: Health Research Board.

Gallagher S, Tedstone Doherty D, Moran R and Kartalova-O'Doherty Y (2008) *Internet use and seeking health information online in Ireland: Demographic characteristics and mental health characteristics of users and non users*. HRB Research Series 4. Dublin: Health Research Board.

Tedstone Doherty D, Moran R and Kartalova-O'Doherty Y (2008) *Psychological distress, mental health problems and use of health services in Ireland*. HRB Research Series 5. Dublin: Health Research Board.

Connolly J, Foran S, Donovan A, Carew A and Long J (2008) *Crack cocaine in the Dublin region: an evidence base for a Dublin crack cocaine strategy*. HRB Research Series 6. Dublin: Health Research Board.

Acknowledgements

The authors would like to thank all of the research participants for their cooperation with the in-depth interviews. We would also like to thank the members of the Intersectoral Crack Cocaine Strategy Group (ICCSG) for their enthusiastic support throughout this study and for their comments on an earlier draft of this report. ICCSG members include Ms Caitriona Brady, Ms Marie Metcalfe, Inspector Brendan Burke, Mr Chris Butler, Dr Des Crowley, Mr Niall Cullen, Mr John Cunanne, Mr Joe Doyle, Inspector Fergus Dwyer, Superintendent Mick Feehan, Mr Tony Gregory TD, Inspector Gus Keane, Mr Seanie Lambe, Mr Charlie Lowe, Mr Mel MacGiobáin, Mr Ruari McAuliffe, Mr Fergus McCabe, Detective Superintendent Barry O' Brien, Mr Peter O' Connor and Ms Anna Quigley. Our thanks to the Department of Justice, Equality and Law Reform for funding the research (data collection and analysis) and to the Health Service Executive for providing funding for this publication. We would also like to acknowledge the assistance of Dr John O'Connor and Mr Seamus Noone of the Drug Treatment Centre Board. The authors would like to thank the external reviewers, Dr Michael O'Connell and Dr Eoin O'Sullivan. Finally, we wish to acknowledge the ongoing assistance of our colleagues in the Alcohol and Drug Research Unit and elsewhere in the Health Research Board.



Contents

List of tables and figures	11
Abbreviations	13
Glossary of terms	15
Executive summary	17
Part 1 Introduction	21
1 Introduction and study design	22
1.0 Overview	22
1.1 Background and study rationale	22
1.2 What is crack?	24
1.3 Research aims and objectives	25
1.4 Methods and data sources	25
1.5 Ethical procedures	29
1.6 Data limitations	29
1.7 Format of this report	30
Part 2 Crack cocaine in the Dublin region	31
2 Emergence and current extent of crack use in the Dublin region	32
2.0 Overview	32
2.1 Introduction	32
2.2 Criminal justice data – cocaine and crack seizures	33
2.3 Prevalence and harm-reduction data	34
2.4 Crack users in treatment	36
2.5 Crack use in local drugs task force areas	37
2.6 Key findings	40
3 Dublin crack cocaine market	41
3.0 Overview	41
3.1 Introduction – understanding drug markets	41
3.2 The organisational structure of the Dublin crack market	43
3.3 Avoiding detection: dealer risk-management strategies	44

3.4	Marketing crack	47
3.5	Crack houses	48
3.6	Price and purity	49
3.7	Key findings	50
4	Profile of Dublin crack users	52
4.0	Overview	52
4.1	Introduction – crack users: ‘the marginalised among the marginalised’	52
4.2	Crack use and gender	53
4.3	Crack use and age	53
4.4	Crack use among young people	54
4.5	Education levels among crack users	56
4.6	Accommodation status of crack users	56
4.7	Key findings	57
5	Patterns of crack use and routes of administration	58
5.0	Overview	58
5.1	Introduction	58
5.2	Crack and other drugs	59
5.3	Crack and opiates	60
5.4	Crack cocaine and powder cocaine	62
5.5	Crack and intravenous cocaine use	62
5.6	Routes of administration	63
5.7	Frequency of use	64
5.8	Key findings	66
Part 3	Consequences of crack use	67
6	Crack-related crime	68
6.0	Overview	68
6.1	Introduction: the drugs–crime linkage	68
6.2	Psycho-pharmacological crime: crack and violence	70
6.3	Economic compulsive crime: crack and acquisitive crime	72
6.4	Systemic crime: gangland violence	76
6.5	Common cause model	76
6.6	Key findings	77

7	Social consequences of crack use for the user, the family and the community	78
7.0	Overview	78
7.1	Introduction: social consequences of crack use	78
7.2	Homelessness	78
7.3	Employment	80
7.4	Implications for the family	81
7.5	Crack in the community	83
7.6	Key findings	85
8	Health consequences of crack use	86
8.0	Overview	86
8.1	Introduction: health consequences of crack use	86
8.2	Physical consequences of crack use	87
8.3	Psychological consequences of crack use	89
8.4	Key findings	90
	Part 4 Responding to crack cocaine: towards a crack cocaine strategy	91
9	Treating crack use	92
9.0	Overview	92
9.1	Introduction	92
9.2	Current treatment responses to crack misuse in Dublin	92
9.3	Attracting crack users into treatment	94
9.4	Retaining crack users in treatment	96
9.5	Improving or providing treatment services: practitioners' perspectives	97
9.6	Treating polydrug use	98
9.7	Key findings	99
10	Policing crack markets	100
10.0	Overview	100
10.1	Introduction: responding to drug supply	100
10.2	An Garda Síochána: supply control activity	102
10.3	Supply reduction: the challenges	103
10.4	Price and the demand for crack	104

10.5	Arrest referral: diverting users into treatment	105
10.6	Drug offences and sentencing	106
10.7	Key findings	106
Part 5 Towards a crack cocaine strategy		109
11 Discussion and research implications		110
11.0	Overview	110
11.1	Improving the evidence base relating to crack cocaine – monitoring and further research	110
11.2	Responding to crack markets and crack-related crime	112
11.3	Reducing the harm that crack cocaine causes both to individuals and communities	114
11.4	Conclusion	115
References		117
Appendix A:	An evidence base for treating cocaine and crack cocaine	126
Appendix B:	An evidence base for crack cocaine law enforcement	133
Appendix C:	Recent HRB series publications	138

List of tables and figures

Tables

Table 1.1	Number of interviews with service providers in local drugs task force areas, 2007	26
Table 2.1	Number of cases who lived in Dublin and were treated for cocaine as a problem drug, as reported to the NDTRS, 2004 to 2006	36
Table 2.2	Number of new cases who lived in Dublin and reported crack cocaine as a problem drug, by task force area of residence, as reported to the NDTRS, 2004 to 2006	38
Table 4.1	Number of new cases who lived in Dublin reported crack cocaine as a problem drug, by age commenced treatment, as reported to the NDTRS, 2004 to 2006	53
Table 4.2	Number (%) of new cases who lived in Dublin and reported crack cocaine as a problem drug, by age commenced use, as reported to the NDTRS, 2004 to 2006	54
Table 4.3	Number of new cases who lived in Dublin and reported crack cocaine as a problem drug, by highest level of education completed, as reported to the NDTRS, 2004 to 2006	56
Table 4.4	Number of new cases who lived in Dublin and reported crack cocaine as a problem drug, by accommodation status, as reported to the NDTRS, 2004 to 2006	57
Table 5.1	Number of cases who lived in Dublin and were treated for problem crack cocaine use, by treatment status, as reported to the NDTRS, 2004 to 2006	59
Table 5.2	Number of cases who lived in Dublin and were treated for crack cocaine as a main problem drug, by treatment status, as reported to the NDTRS, 2004 to 2006	59
Table 5.3	Number of cases who lived in Dublin and were treated for crack cocaine as an additional problem drug, by treatment status, as reported to the NDTRS, 2004 to 2006	60
Table 5.4	Route of administration of crack cocaine reported by new cases in the month prior to treatment, 2004 to 2006	64
Table 5.5	Number (%) of new cases who lived in Dublin and reported crack cocaine as a problem drug, by frequency of use, as reported to the NDTRS, 2004 to 2006	65
Table 7.1	Employment status of new cases of crack cocaine use, 2004 to 2006	80
Table 10.1	Number of new cases who lived in Dublin and reported crack cocaine as a problem drug, by source of referral, as reported to the NDTRS, 2004 to 2006	106

Figures

Figure 2.1	Trends in the number of seizures of selected drugs, excluding cannabis, 2000–2006	33
Figure 5.1	Number of cases who lived in Dublin and were treated for crack cocaine, by other types of problem drugs used alongside it, as reported to the NDTRS, 2004 to 2006	60

Abbreviations

ADRU	Alcohol and Drug Research Unit
GNDU	Garda National Drugs Unit
HRB	Health Research Board
ISCCSG	Intersectoral Crack Cocaine Strategy Group
LDTF	Local Drugs Task Force
NACD	National Advisory Committee on Drugs
NDTRS	National Drug Treatment Reporting System
ROSIE	Research Outcome Study in Ireland

Glossary of terms

Benzos: The street name for benzodiazepines, which are an effective treatment for anxiety, insomnia and some forms of epilepsy and spasticity. Benzodiazepines are required only when the disorder is severe, disabling or subjecting the individual to extreme distress. It is recommended that benzodiazepines are prescribed for short periods only. Dependence is now recognised as a significant risk in patients receiving such medication for longer than one month.

Crack cocaine: A form of smokeable cocaine sold at street level in small lumps or 'rocks'. Crack is formed by dissolving powder cocaine (cocaine hydrochloride) in water, to which an alkali (such as ammonia, sodium bicarbonate or sodium hydroxide) is added; the mixture is heated and then dried into hard smokeable lumps. These lumps contain not only alkaloid cocaine but sodium bicarbonate and whatever other filters and adulterants had been added to the original cocaine powder. The name crack is derived from the cracking sound made when 'rocks' are being heated and smoked. Smoking crack produces a rapid intense high which lasts for about two minutes, and is followed by a less intense but pleasurable feeling which lasts for about 20 minutes.

Freebase: A purer form of crack cocaine where, before it solidifies, the alkaloid cocaine is dissolved in a solvent (such as ether) and gently heated to ensure that the remaining liquid is evaporated. When ignited, the resulting product produces vapours of relatively pure cocaine. Essentially, freebase has an additional purification process and delivers to the user purer cocaine than either powder cocaine or crack cocaine.

Halfway house: A rehabilitation facility for individuals who no longer require the full services of a hospital or other institution, but who are not yet ready to return to their communities.

Intranasal: Means 'within the nose' and, in this report, refers to the administration of substances such as powder cocaine which can be snorted using a rolled banknote, for example.

Intravenous (IV): Means 'within a vein', and normally refers to the administration of medications or fluids (solutions) through a needle or tube inserted into a vein, which allows immediate access to the blood supply.

Mainlining: A lay term for intravenous drug use.

Poppers: The street or popular name for various alkyl nitrites, including isobutyl nitrite, butyl nitrite, and amyl nitrite; used as a stimulant drug producing a brief euphoric effect.

Powder cocaine: Cocaine hydrochloride, the most commonly used form of cocaine; a white crystalline powder which can be taken intranasally or which, when dissolved in water, can be taken intravenously (by vein).

Problem drug use: Defined by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) as injecting drug use or long-duration/regular use of opioids, cocaine (including crack) and/or amphetamines.

Recreational drug use: The use of drugs for pleasure or leisure; characteristically regular but controlled, usually taking place in a social group and meeting a variety of individual and group needs. The term is often used to denote the use of ecstasy and other 'dance drugs', and implies that drug use has become part of someone's social life, even though they may take drugs only occasionally.

Skin pop: When a drug is injected beneath the skin rather than into a vein or muscle.

Executive summary

Background and study design

Crack cocaine is produced from powder cocaine using readily available chemical agents such as ammonia or baking soda. Smoking crack is a highly efficient way of getting cocaine into the brain, making its use compulsive and difficult to control in some cases. In early 2005, a number of seizures of crack cocaine were made by An Garda Síochána in Dublin's north-inner city. In addition, there were anecdotal reports of individuals using crack cocaine in Dublin. As a result, the Intersectoral Crack Cocaine Strategy Group (ISCCSG) was established in the north-inner city in March 2006.

The group decided to document the nature and extent of crack use; the availability of crack; the impact of crack on the user, the family and the wider community; and current treatment and policing responses to crack use.

The Alcohol and Drug Research Unit (ADRU) of the Health Research Board (HRB) was commissioned to complete the study using a rapid situation assessment method. The study involved a review of findings from relevant research, the collection and analysis of up-to-date drug-treatment and criminal justice data, and interviews and focus groups with crack users, service providers and the Garda National Drugs Unit. The study received ethical approval in August 2007.

The key findings are presented in the following paragraphs.

Nature and extent of crack use

Some Dublin-based drug-treatment services have been aware of small numbers of clients using crack since the late 1990s, but the number of cases presenting for treatment began to reach double figures in 2003. Since 2004, treatment services in every local drugs task force area in Dublin have reported at least one case of crack cocaine use among their clients. A number of factors may explain the emergence of crack cocaine. These include the increased availability of powder cocaine; the presence of problematic opiate users who have previously used crack cocaine in the UK or elsewhere in Europe and have returned to using crack cocaine while living in Dublin; and the presence of non-Irish nationals who have access to cocaine supply routes, possibly in West Africa, and who have experience in preparing crack cocaine. Crack cocaine users represent 1% of treated problem drug users and 0.1% of the general population in 2006/7.

Social profile and consequences of crack

A high proportion of crack cocaine users are homeless, unemployed and do not have formal educational qualifications. The lifestyles of most crack users appear to be too chaotic to sustain a legitimate source of income. According to collated data from treatment services, the majority of crack users were male and half were aged between 20 and 29 years. It is reported that females involved in sex work and single mothers develop the most chaotic crack addiction. A number of service providers reported that a proportion of crack cocaine users may be young people who binge on crack but do not engage with treatment services. Compulsive crack users reported neglecting their children, often diverting their financial resources towards buying crack. Given the high price of crack, users can acquire debts very quickly and, if left unpaid, these debts can lead to intimidation from crack dealers. Intimidation may be directed not only at the users themselves but also at their parents or other family members.

Drug-using characteristics of crack users

The vast majority of cases used more than one drug; opiates (mainly heroin) were the most common drugs used alongside crack. Smoking was the predominant mode of administration of crack. A proportion of intravenous powder cocaine users made a transition from injecting powder cocaine to smoking crack cocaine because of the physical harms of injecting. Frequency of use varied from a daily habit to a weekly habit. However, the majority of current crack users participating in the study reported that they would use more crack if they had greater financial resources available to them. Almost two-fifths (37%) of new crack cases entering treatment had commenced its use before the age of 20.

Health consequences of crack use

The most common physical side effects of crack use were breathing problems, heart problems and rapid weight loss, and the most common psychological consequences were paranoia, aggressiveness and depression.

Dublin crack market

Despite targeted Garda operations in 2005/2006, the north-inner city remains the primary crack market in Dublin. This market is dominated by non-Irish national dealers who reportedly import small amounts of cocaine via couriers. A growing number of local Irish dealers are reportedly involved in the distribution of crack throughout the Dublin region and prepared crack has been purchased throughout the city since 2006. Findings indicate that current crack markets operating in Dublin are closed markets, that is, dealers do not sell drugs to strangers, exchanges are normally arranged using a mobile

phone and buyers are directed to specific meeting points outside the inner city for an exchange. Although some dealers, or clients themselves, possessed the skills to prepare crack from cocaine powder, many users believed that dealers who were primarily of West African origin prepared higher quality crack. The price of crack is relatively stable and uniform. According to six users and six drug-treatment services, prepared crack cocaine is being sold in €50 or €100 quantities or 'rocks'. Dealers use a number of methods to market crack, including selling it in combination with other drugs, targeting drug users outside methadone clinics, and offering heroin users crack instead of heroin. Crack users participating in the study described crack houses as locations where crack could be used, and in some cases prepared in exchange for free crack. Crack houses were not reported as major venues for crack dealing or as sites for sex work.

Crack-related crime

Shoplifting, burglary and robbery were reported as common means for users to sustain their crack cocaine habit. Service providers reported an increase in the numbers of women returning to or beginning sex work to fund their crack use. There were no reports of new street-based sex markets; the data indicate that apartments are used for sex work. Crack users rarely reported dealing the drug themselves, but claimed that there were numerous young people involved in using and selling crack. However, service providers said that they had no evidence of young people selling crack. Eleven participants, including both treatment staff and users, reported a rise in the number of aggressive and violent incidents in their localities, involving assaults, gangland violence and fatal shootings. However, it is not clear whether such incidents are related to crack cocaine or to other substances such as powder cocaine or heroin.

Treating crack use

Current treatment responses to crack use, which include complimentary therapies, counselling and cognitive behavioural therapy, evolved from responses to the increase in problematic powder cocaine use. The Health Service Executive reports that 38 staff members have been trained as cognitive behavioural therapists, and Merchants Quay Ireland have trained 53 frontline staff and 76 key workers in cocaine-related responses. The Department of Community, Rural and Gaeltacht Affairs has funded a number of cocaine-treatment initiatives. Internationally, the most successful approaches to reducing or ceasing crack use are psychosocial interventions (such as cognitive behavioural therapy); however, these interventions can only be successful if the user is attracted to and retained in treatment. In order to attract people into a treatment programme, the service provider needs to deal with the immediate needs of the user (such as practical health, social and family issues); in the medium term, the provider must be able to deliver services to increase the user's well-being (such as complementary therapies and

personal development programmes). Some service providers and crack users argue in favour of separate facilities to address cocaine use. Since most crack users are polydrug users, the establishment of stimulant-specific services requires careful consideration. Ireland may need to consider placing outreach and psychosocial treatment at the centre of its addiction services, with the addition of medical interventions such as a specialist support for detoxification (from opiates, alcohol and benzodiazepines), methadone maintenance and psychiatric treatment. There is a widespread perception that the addiction services in Dublin are methadone services only.

Policing crack markets

The evidence indicates that drug-distribution systems adapt quickly, so that a drug supplier who is arrested will quickly be replaced. For example, Operation Clean Street was regarded as a success from a law-enforcement point of view. However, the success of Operation Clean Street raised the issue of the so-called 'Water Bed Effect' whereby drug activity was displaced to other locations around the city. International evidence indicates that effective intervention strategies are those which combine attempts to disrupt local markets, thus rendering them less predictable to both buyers and sellers, with attempts to divert drug offenders into treatment services. There is growing evidence that partnership working between all stakeholders offers the most sustainable method of responding to street-level drug markets. Law enforcement authorities can concentrate their resources in specific locations at particular times and, consequently, are uniquely placed to prevent or disrupt emerging drug markets. Limited sources of crack supply in Dublin may have contributed to the stable high price of crack relative to other drugs. Price increases, where they occur, do not necessarily deter use but may simply lead problematic users to engage in greater levels of crime in order to pay the higher prices. However, this study found some evidence that the high price of crack does deter use among individuals who are not willing to engage in criminal activity.

Conclusion

Many studies of emerging issues face a considerable time gap between data collection and the date of publication of a final report, which may limit the usefulness of the findings in terms of developing a proactive response. The analysis presented in this report was constrained by the limited amount and quality of data available through the criminal justice system and the quality of the data available through the health system. In addition, the researchers were unable to interview young crack users because such users did not attend any health or social services. Despite these limitations, this study provides an adequate analysis of an issue of public concern, within a reasonable timeframe. Furthermore, the main findings of this research are in line with those reported in other countries.

Part 1

Introduction

1 Introduction and study design

1.0 Overview

This section outlines the background to, and rationale for, the study. The research aims and objectives, methodology and data sources are described. This section also identifies the limitations in the data sources used throughout the research.

1.1 Background and study rationale

Crack emerged as a drug of abuse in the US in the mid-1980s, causing particular harm in poor inner-city neighbourhoods (Reinarman *et al.* 1997). In the UK, crack cocaine has been a challenging issue for drug-treatment services and law-enforcement agencies since the mid-1990s, particularly in London (GLADA 2004a). Given the experience of other countries, the emergence of crack cocaine in Ireland has recently become a matter of concern in terms of its potential to cause significant harm to individuals, families and communities where it becomes available. Garda seizures of crack in 2005 underlined the availability of this substance, particularly in Dublin's north-inner city. Operation Plaza, an undercover garda operation targeted at cocaine trafficking in the north-inner city, confirmed the involvement of organised criminal groups, some of which involve non-Irish nationals, in the crack cocaine trade in Dublin (GNDU, personal communication 19 May 2006; O'Regan, 3 February 2003; O'Keefe, 8 March 2005). There was also anecdotal evidence of crack's emergence in other areas of the city (Gregory 2006).

Information from service providers and data from the National Drug Treatment Reporting Service (NDTRS) suggest that some drug-treatment services have been aware of small numbers of clients using crack since the late 1990s, but that larger numbers of cases began presenting for treatment only in 2003, mainly in north Dublin. In 2006, a Dublin-based survey of drug-treatment services found that, out of 28 services surveyed, 10 could report the use of crack cocaine in their locality (CityWide 2006). While seizure and treatment figures remained relatively small in relation to the overall number of drug seizures and cases treated, the trend appeared to be upwards in both cases. The issue of crack cocaine was also beginning to emerge as a concern for those participating in the ongoing activities of the North-Inner City Community Policing Forum. This forum is a community policing partnership that brings together the local community, An Garda Síochána, Dublin City Council and other stakeholders to address local drug issues (Connolly 2002).

In the light of these concerns, it was felt that there was a need to develop an early response before the situation got out of control. As an initial step in the development of a crack cocaine strategy, the Intersectoral Crack Cocaine Strategy Group (ISCCSG) was established in March 2006 under the auspices of the Community Policing Forum. This group is chaired by Mr Tony Gregory, TD for Dublin Central, and is made up of representatives of the following organisations:

- Department of Justice, Equality and Law Reform
- An Garda Síochána
- Garda National Drugs Unit (GNDU)
- Health Service Executive
- Dublin City Council
- CityWide Drugs Crisis Campaign
- Neighbourhood Youth Project 2
- Union for Improved Services, Communication and Information (UISCE)
- National Drugs Strategy Team
- City Clinic
- Alcohol and Drug Research Unit of the Health Research Board
- North-inner city Community Policing Forum
- North East Inner City LDTF
- Inner City Organisation Network (ICON)
- Office of the Refugee Applications Commissioner
- Inner City Renewal Group
- North Wall Residents Association

The objectives of the ISCCSG are to:

- establish and improve the evidence base relating to crack cocaine;
- reduce the harm that crack cocaine causes both to communities and crack users;
- reduce the availability of crack cocaine;
- pursue 'primary prevention', so that fewer people ever start using crack cocaine;
- protect communities from crime related to crack cocaine;
- value the diversity of communities and actively seek to involve them in the response to crack cocaine;
- promote both an inter- and a multi-agency response to crack cocaine;
- undertake to evaluate the process.

In line with the first objective, the ISCCSG requested that the Alcohol and Drug Research Unit (ADRU) of the Health Research Board (HRB) conduct research to establish the evidence base relating to crack cocaine in the Dublin region as a necessary first step in the development of a focused and long-term strategic response.¹

Funding for the study was provided by the Department of Justice, Equality and Law Reform in January 2007. The research proposal was scientifically and methodologically validated by two external peer reviewers in May 2007, and received ethical approval in August 2007. The study adopted a twelve-month timeframe to complete all aspects of research and produce a report. Fieldwork commenced in August 2007.

1.2 What is crack?

Crack is the name given to a freebase form of cocaine that is processed from cocaine hydrochloride (powder cocaine).² In order to produce crack cocaine, powder cocaine is combined with ammonia or sodium bicarbonate (baking soda) and water and heated to remove the hydrochloride, until it forms small, solid-white or cream-coloured rocks.³ The rocks are then filtered from the original solution, washed with water and left to dry (Drugscope 2005). Crack gets its name from the cracking sound it makes when it is heated. It is usually smoked in a pipe, glass tube, plastic bottle or piece of tinfoil. It is also possible to use crack cocaine intravenously by preparing the solid rocks of crack cocaine with a transforming agent such as lemon juice or vinegar, and by applying heat to the mixture. Smoking crack is a highly efficient way of getting cocaine into the brain and provides a more intense experience than snorting powder cocaine (GLADA 2004a).⁴ When crack is smoked, the user may experience a high in less than 10 seconds. The intensity of the experience of smoking crack means that its use can become compulsive and difficult to control for some users (GLADA 2004a).

Until recently, the addictive properties of crack (and of cocaine in general) were thought to be purely psychological. However, research since the 1980s suggests that cocaine and other stimulants may produce neuro-physiological disturbances that outlast drug use (Levin *et al.* 2001). Essentially, unlike the withdrawal symptoms that occur with opiates, withdrawal from cocaine manifests in psychological rather than physiological symptoms. During a surge in crack use throughout the 1980s, there was

1 A similar approach was taken by the Greater London Alcohol and Drug Alliance (GLADA) which, in seeking a better understanding of the scale and nature of the problem, commissioned two reports on the use and sale of crack cocaine in London (GLADA 2004a, GLADA 2004b). These reports provided the basis for the 2005–2008 Crack Cocaine Strategy which is in place in London (GLADA 2004c).

2 To avoid confusion, crack cocaine is referred to as 'crack' or 'crack cocaine' throughout this report and cocaine hydrochloride is referred to as 'powder cocaine'. See the glossary of terms for further detail.

3 Crack cocaine can be differentiated from freebase cocaine. However, to avoid confusion, both substances are referred to as crack in this report. See the glossary of terms for further detail.

4 Cocaine causes a build-up of dopamine in the synapse which contributes to the pleasurable effects of the drug. For more detailed information on the pharmacological effects of cocaine, see www.nida.nih.gov

extensive reporting in the US about the extremely addictive nature of crack. These reports typically claimed that crack was instantly addictive. However, such assertions are not supported adequately by scientific evidence. The effects of crack use, like those of most drugs, are influenced by the characteristics of users and their social circumstances (Drugscope 2005; Morgan and Zimmer 1997).

1.3 Research aims and objectives

The aim of the research was to establish an evidence base for crack cocaine use in the Dublin region.⁵ The research objectives were to:

- Establish the nature and extent of crack cocaine use and its availability in the Dublin region.
- Identify the impact of crack cocaine on the user, the family and the wider community.
- Document current responses, if any, to crack cocaine use, and the outcomes of those responses where available.
- Develop a practical working document for discussion and communication targeted at local decision makers and stakeholders and upon which an evidence-based crack cocaine strategy can be developed.

1.4 Methods and data sources

The research was conducted over a nine-month period, using a rapid situation assessment technique recommended by the World Health Organization (World Health Organization 2002). The aim of rapid situation assessments is to gather information from multiple data sources within a defined timeframe, using a number of data-collection techniques (UNDCP 1999). This technique has gained popularity in the substance abuse field since the 1990s as a means of identifying and analysing drug-related problems in a specific area rapidly (Fitch and Stimson 2003). A rapid situation assessment is particularly suitable in this instance, as the extent of crack cocaine use in the Dublin region requires immediate assessment so that measures can be put in place to avoid an escalation of the problem. This study drew on a number of sources of existing information that are usually available in varying forms, including official statistical data and research reports. The study also involved original research, such as key informant interviews, focus groups and analysis of drug-treatment data.

Key informant interviews and focus groups

⁵ The research focused on the Dublin region, as both Garda reports of seizures and anecdotal evidence from community groups suggested that crack use had not expanded beyond Dublin to any significant extent.

Primary research included 36 semi-structured interviews and 5 focus groups with key informants which were conducted from August 2007 to February 2008. It consisted of:

- 10 in-depth interviews with former or current crack users;
- 26 in-depth interviews and 2 focus groups with respondents working in drug-treatment and outreach services;
- 3 focus groups with respondents from the Garda National Drug Unit (GNDU), a Dublin city homeless service and drug users' forum.

In addition to these interviews and focus groups, data was also used from a focus group with the GNDU, which was conducted following a crack cocaine specific operation (Operation Plaza) in May 2006.

To ensure a thorough investigation of the Dublin region, interviews were conducted in 11 of the 12 local drugs task force (LDTF) areas in the region⁶ (Table 1.1). The only task force area in Dublin not included in the interviews was Dun Laoghaire Rathdown.⁷

Table 1.1 Number of interviews with service providers in local drugs task force areas, 2007

Local drugs task force areas	Number of interviews/focus groups
North-inner city	10
Canal Communities and South Inner City	5
Dublin North East	5
Tallaght	3
Blanchardstown	2
Ballyfermot	2
Clondalkin	1
Crumlin	1
Finglas	1
Ballymun	1
Total	31

⁶ The Dublin region comprises the administrative areas of Dublin City Council, Fingal County Council, Dun Laoghaire-Rathdown County Council and South Dublin County Council.

⁷ A number of services in the Dun Laoghaire and Rathdown LDTF reported having no experience with crack at the time fieldwork was being conducted. However, since fieldwork was completed, one drug-treatment service has confirmed the use of crack in this location.

Ten interviews were conducted with current or former crack users. A number of these participants were recruited through drug-treatment and social services. A purposive sampling procedure was used to recruit participants.⁸ In light of the fact that crack users may not access treatment or social services, the research team also used a snowball sampling procedure to recruit participants outside drug-treatment and social services. This involved using respondents identified through treatment services to assist in recruiting other crack users known to them who were not in treatment.

The interviews and focus groups were audio-taped and transcribed verbatim. The transcribed data was entered into NVivo (qualitative data analysis software) and analysed using a coding scheme based on the interview guide.⁹ Key themes in each interview and focus group were identified and categorised according to their code and the similarities and differences within these key themes were examined.

Drug-treatment data

The National Drug Treatment Reporting System (NDTRS) is an epidemiological database on treated problem drug and alcohol use in Ireland.

Drug-treatment data are viewed as an indirect indicator of drug and alcohol misuse as well as a direct indicator of demand for treatment services. NDTRS data are used at both a national (alcohol and drug data) and European level (drug data) to provide information on the characteristics of clients entering treatment, and on patterns of substance misuse, such as types of substance used and consumption behaviours.

For the purpose of the NDTRS, treatment is broadly defined as 'any activity which aims to alleviate the psychological, medical or social state of individuals who seek help for their substance misuse problems'. Drug-treatment options include one or more of the following: medication (detoxification, methadone reduction, substitution programmes and psychiatric treatment); brief intervention; counselling; group therapy; family therapy; psychotherapy; complementary therapy; and/or life skills training.

Compliance with the NDTRS requires that one form be completed for each new client coming for first treatment and for each previously treated client returning to treatment for problem substance use. Service providers at treatment centres throughout Ireland collect data on each individual who attends for first treatment or returns to treatment between 1 January and 31 December each year.

8 Using a purposive sampling procedure, respondents are chosen because they have particular features or characteristics which will enable detailed exploration of the research objectives (Robson 2002).

9 Nvivo is software that facilitates the analysis of qualitative data (e.g. in-depth interviews, field notes, focus groups etc.) in a systematic fashion.

The main elements of the reporting system are defined as:

All cases treated – describes individuals who receive treatment for cocaine use at each treatment centre in a calendar year, and includes:

Previously treated cases – describes individuals who were treated previously for cocaine use at any treatment centre and have returned to treatment, and

New cases treated – describes individuals who have never been treated for problem cocaine use; and

Status unknown – describes individuals whose status with respect to previous treatment for problem cocaine use is not known.

The analysis provides an outline of the following: numbers treated for problem cocaine and crack use in Dublin; main problem drugs; additional problem drugs; risk behaviours and socio-demographic characteristics of cases.

Criminal justice data

Although the number of drug seizures in any given period can be affected by such factors as law-enforcement resources, strategies and priorities, and by the vulnerability of traffickers to law-enforcement activities, drug seizures are considered as indirect indicators of the supply and availability of drugs (Connolly 2005). Information on the number of crack seizures and crack-related arrests in the Garda North Central Division was provided by the Garda National Drugs Unit. The gardaí have highlighted potential difficulties with reporting crack seizures accurately. For example, seizures of powder cocaine intended to be manufactured into crack cocaine are reported as 'powder cocaine seizures'. This will in effect lead to an under-reporting of the overall number of seizures of crack cocaine (GNDU, personal communication, May 2008).

It is important to gather information regarding the price and purity of illicit drugs, as analysis of these factors can add to the understanding of drug markets. Drug price data enable us to estimate the value of the illicit drug market. Identifying data on the relative price and purity of drugs also allows us to compare different stages or levels of the market and to assess supply-control measures (Connolly 2005). For example, lower prices suggest a higher availability of crack cocaine (Burgess 2003). Information about the value of the illicit drug market can also provide an indication as to its relative importance in local economies. Lenke and Olssen (1998: 11) suggest that the price and purity of drugs can be affected by the level of market organisation. More sophisticated markets are, they suggest, 'characterised by a fairly good balance between supply and demand' which leads to relatively stable drug price and purity. Chemical drug profiling

also offers potential to trace supply routes and to link drug dealers. Data on crack prices was sought from research participants.

Seizures of heroin, cocaine and amphetamines by gardaí and by Customs officials are analysed and quantified at the Forensic Science Laboratory of the Department of Justice. By 'analysed', scientists mean the samples are tested for the presence of an illicit substance; by 'quantified', scientists mean that the percentage purity of the sample is identified. Purity is a concept which arises where there is a question of adulteration or dilution of an otherwise pure substance. However, drug purity testing is not routinely undertaken by the Forensic Science Laboratory (Connolly 2005; GNDU, personal communication, May 2008).

Secondary research data

Data from previous studies and surveys are useful indicators of the prevalence of crack use in Dublin. These studies include the general population survey on drug use (NACD and DAIRU 2008), research estimating the prevalence of drug use among homeless people (Lawless and Corr 2005), a study examining the nature and extent of drug use among the Traveller population (Fountain 2006), the Research Outcome Study (ROSIE) (Cox *et al.* 2006), the pilot report from the National Drug Trend Monitoring System (NACD 2007a) and data from the CityWide Drugs Crisis Campaign study on cocaine use in Dublin communities (CityWide 2006; CityWide 2004).

1.5 Ethical procedures

Ethical approval for this study was received from the Drug Treatment Centre Board on 14 August 2007. The principle of 'informed consent' was followed throughout the research, and confidentiality and anonymity were afforded to all participants. Although the research was focused on LDTF areas, the precise locations in which certain research findings were made are concealed in some cases in order to preserve the anonymity of an individual respondent, or to prevent the specific site from developing a reputation as a drug market.¹⁰

1.6 Data limitations

There are a number of limitations to the data available for this study.

With respect to the in-depth interviews and focus groups, the researchers were unable to locate any young crack users for interview, and were dependent on the user and service providers' reports to describe this group.

¹⁰ The concern with consolidating a reputation does not arise in the case of LDTF areas. LDTFs were established in these areas due to the presence of serious drug problems.

With regard to 'previously treated cases' in the NDTRS data, there is a possibility that individuals appear more than once in the database: for example, where a person receives treatment at more than one centre. In addition, the return forms in relation to the majority of cases of cocaine use reported to the NDTRS did not specify the type of cocaine used. Of the 2,955 reported cases in the three years 2004 to 2006, almost three-quarters (74%, 2,197) did not provide this information. Of the 790 cases who did identify the type of cocaine used, 655 (83%) used powder cocaine, and 135 (17%) used crack cocaine. It is important that service providers ask cocaine users to specify the type of cocaine used and how they use it, so that clients' care plans can address crack use and to also allow the NDTRS to obtain a more complete record of cocaine use in Ireland.

Because the seizure data provided by Garda authorities relates to a particular operation in the North Central Garda Division, they are of limited value as an indicator of crack availability throughout Dublin. Garda authorities have highlighted several difficulties in reporting crack seizures accurately. For example, seizures of powder cocaine that are intended to be manufactured into crack cocaine are reported as 'powder cocaine seizures'. As noted above, drug purity testing is not routinely undertaken by the Forensic Science Laboratory. Had they been available, the results of forensic analysis of possible crack cocaine seizures would have been useful to this study.

1.7 Format of this report

This report is divided into five parts. Part 1 includes the introduction. Part 2 (Sections 2–5) reviews the emergence and current extent of crack cocaine in the Dublin region, describes the market for crack, and profiles crack users and the patterns and methods of crack use. Part 3 (Sections 6–8) considers the criminal, social and health consequences of crack use. Part 4 (Sections 9–11) looks at current treatment and policing responses to crack use. Each section of the report begins with a brief overview of the topics to be covered. The introduction to each section considers the main findings of the international literature on the subject. We then present the findings of the present research and conclude each section with a list of the key findings. In Part 5 (Section 11) these key findings are discussed and their implications in terms of the development of a strategic response to crack cocaine are considered. This discussion should be considered in conjunction with Appendices A and B which provide a brief review of evidence-based practices in the areas of treatment and policing respectively.

Part 2

Crack cocaine in the Dublin region

2 Emergence and current extent of crack use in the Dublin region

2.0 Overview

This section reviews the emergence, growth and prevalence of crack use in the US and Europe since the 1980s. Using a variety of data sources, the emergence and current extent of crack use in the Dublin region is then described.

2.1 Introduction

In the US, crack use escalated in the mid-1980s, particularly among African-American and Latino communities in marginalised inner-city neighbourhoods (Reinarman *et al.* 1997). US research suggests that the use of targeted marketing strategies by drug suppliers was one of the principal reasons why the demand for crack cocaine was created. Unlike powder cocaine, crack was sold in smaller and cheaper amounts, thus making it financially more accessible to the urban poor (NIDA 2004; Reinarman *et al.* 1997).

In Europe, there is strong evidence to suggest that the extent of crack cocaine use is considerably lower than that of powder cocaine use. Furthermore, crack users account for only 2.5% of all European drug users in drug treatment (EMCDDA 2007a, 2007b). However, it must be noted that estimating the extent of crack use among the general population is problematic; this is because research suggests that the use of crack cocaine is concentrated among marginalised sub-populations who may be relatively inaccessible to drug-prevalence studies. In the UK, the number of problematic crack cocaine users has grown since the mid-1990s (particularly in London) (GLADA 2004a). It is estimated that 1.5% of London's population aged between 15 and 44 years are crack cocaine users. Although UK research has not underlined the link between price and an escalation in crack use, test purchase data from the Metropolitan Police Service suggests that the price of crack cocaine halved in the mid-1990s and has decreased slowly since (GLADA 2004a).

2.2 Criminal justice data – cocaine and crack seizures

Figure 2.1 presents data on drug seizures by An Garda Síochána and Customs Drug Law Enforcement. The data show trends in the numbers of seizures of a selection of drugs between 2000 and 2006. As Figure 2.1 illustrates, seizures of cocaine have increased steadily and considerably since 2000. In 2004, cocaine seizures surpassed heroin seizures for the first time, and by 2005 they had outnumbered seizures of ecstasy-type substances.

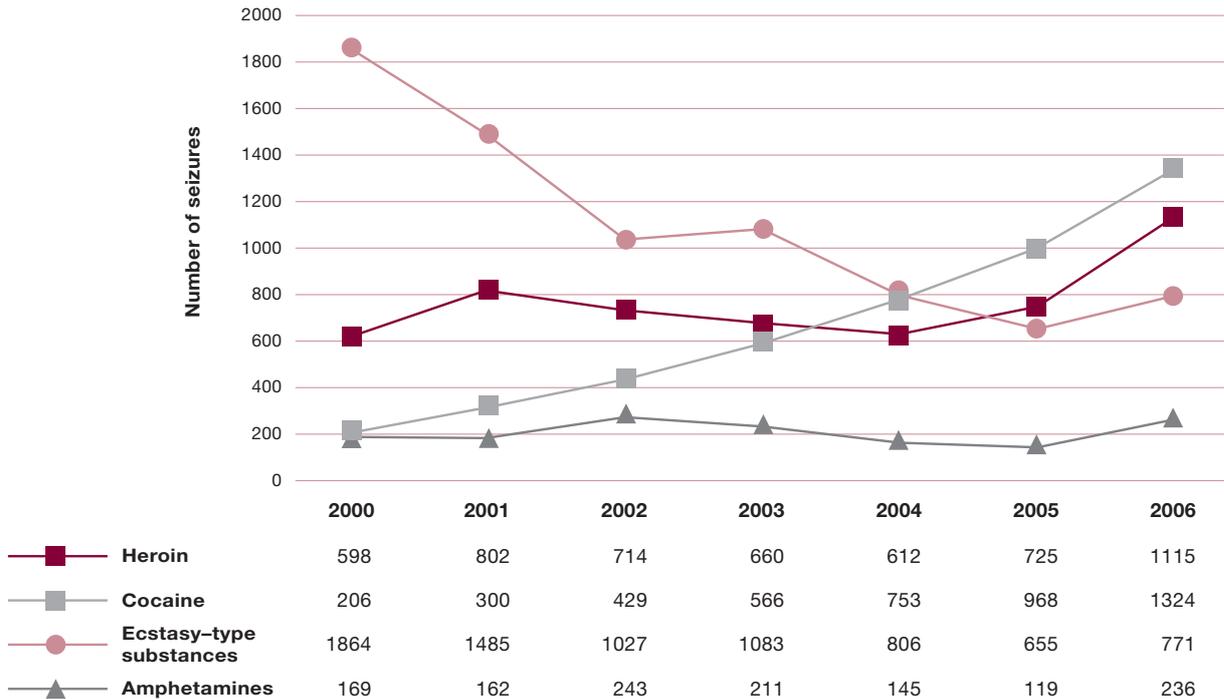


Figure 2.1 Trends in the number of seizures of selected drugs, excluding cannabis, 2000–2006

Source: Annual reports of An Garda Síochána 2000–2006

The first reported seizure of crack cocaine appeared in the report of An Garda Síochána for 1995 and seizures of ‘small amounts’ of crack cocaine were reported in 1996 (An Garda Síochána 1996; An Garda Síochána 1997). Since 1998, crack has not been reported as a separate drug from cocaine in the annual reports of An Garda Síochána.

In 2003, the Forensic Science Laboratory and the Garda National Drugs Unit (GNDU) undertook a project to screen cocaine seizures for crack. Out of the 122 seizure samples tested, only 4 were found to have contained crack cocaine (Raggett *et al.* 2003). In 2006, Operation Plaza was launched by An Garda Síochána to examine the crack market in Dublin and to establish a broad picture of the extent of the crack problem. Reports from Operation Plaza suggested that non-Irish nationals may have initially provided the supply of crack in Dublin. However, according to the GNDU, a relatively small amount of crack was being imported; cocaine was normally imported and sold as powder cocaine, which users themselves prepared as crack. Non-Irish nationals generally imported directly from West Africa. These dealers were regarded by the gardaí as having quite a sophisticated importation system. Unlike Irish dealers, who, it was reported, generally attempted to import 10 kilos or so at a time, non-Irish national dealers tended to use 10 separate couriers to import 1 kilo each (GNDU, personal communication, 19 May 2006). According to the GNDU, between January 2005 and December 2007 there were 23 seizures of crack cocaine in the Dublin North Central Division.

2.3 Prevalence and harm-reduction data

Prevalence of crack use among the general population

In 2006-2007, a very low proportion (0.6%) of adults in Ireland aged 15 to 64 years reported that they had used crack cocaine at some point in their life (NACD and DAIRU 2008). The lifetime use of crack cocaine was most common among men (at 0.8%) and young people (at 1.5%). When the survey results were examined by place of residence, the proportion of the population who had ever used crack cocaine in south-west Dublin, Wicklow and Kildare was the same as that among the general population. One in 200 adults living in north Dublin reported that they had used crack cocaine at some point in their life. Almost 1% of the population living along the south-east coast of Dublin and Wicklow had ever tried crack cocaine. The authors of the report note that problem drug users are under-represented in general population surveys due to their nomadic and chaotic existence. Special techniques such as 'capture-recapture' are required to estimate the true number of crack cocaine users in Ireland, but we currently do not have the appropriate reporting procedures and data to facilitate such methods.¹¹ This limits our ability to estimate the true size of the population.

¹¹ The capture-recapture methodology (CRM) is a method for estimating the prevalence of partially hidden populations such as drug users; it involves combining data from multiple sources.

Prevalence of crack use among homeless people

Lawless and Corr (2005) at Merchants Quay Ireland assessed the nature, extent and experience of alcohol and drug use among people who were homeless in four cities in Ireland – Cork, Dublin, Galway and Limerick – between June and October 2003.¹² In Dublin, the sample was selected using a quota sampling based on gender, age and primary accommodation type, while in Cork, Galway and Limerick the quota sample was based on primary accommodation. The majority (247, 70%) of the sample was recruited in Dublin and the remainder (108, 30%) was recruited in the other three cities. Of the 355 participants, 19% had used crack cocaine at some point in their life and 3% were using crack cocaine in the month prior to the survey.

Nature and extent of crack use among Travellers

In 2005, Professor Jane Fountain of the University of Central Lancashire assessed the nature and extent of illicit drug use in the Traveller community in Ireland (Fountain 2006). The qualitative information presented in this report indicates that crack cocaine was rarely used by the Traveller population.

Pilot national drug trend monitoring report

The national drug trend monitoring system pilot study investigated emerging national drug use patterns in Ireland by collecting information from 156 drug workers who had regular contact with drug users in October 2004 (NACD 2007a). Just under one-third (32%) of drug workers reported that crack cocaine was used by their clients, and just over a half of these reported an increase in its use by their clients. Crack cocaine was also identified by 10 respondents as being a newly available drug in their area in the previous 12 months.

Nature and extent of crack use among attendees at harm reduction and treatment

In an unpublished analysis, 15 of 28 needle-exchange services' representatives in Dublin, Kildare and Wicklow reported that crack cocaine was the fourth most common drug used by needle and syringe-exchange attendees in 2007. The routes of administration for crack were either through injecting or smoking. Three services reported an increase in the combined use of cocaine and heroin. This involved either smoking crack cocaine or injecting powder cocaine and the subsequent use of heroin to 'bring clients down' from the cocaine-related high (J Robinson, HRB, personal communication, 2008).

¹² Merchants Quay Ireland is a voluntary organisation providing a wide range of services to people who are homeless and for drug users.

2.4 Crack users in treatment

NDTRS data

Just over 1% (135/10,418) of treated problem drug users who lived in Dublin and entered treatment between 2004 and 2006 reported crack cocaine as one of their problem drugs.

According to the NDTRS, 10,418 cases with Dublin addresses entered treatment for problem drug or alcohol use between 2004 and 2006, of whom 2,955 (28%) had cocaine listed as one of their problem drugs. Although the total number of cocaine cases presenting for treatment peaked in 2005 and decreased marginally in 2006, the number reporting cocaine as a problem drug increased by 18%, from 913 in 2004 to 1,073 in 2006 (Table 2.1). Of the 2,955 reported cases in the years 2004 to 2006, almost three-quarters (74%, 2,197) did not specify the type of cocaine used. Of the 790 cases who did specify the type of cocaine used, 655 (83%) used powder cocaine, and 135 (17%) used crack cocaine (Table 2.1).

Table 2.1 Number of cases who lived in Dublin and were treated for cocaine as a problem drug, as reported to the NDTRS, 2004 to 2006

Cocaine type	Year treated			Total
	2004	2005	2006	
All cases*	913	969	1073	2955
Cocaine unspecified	850	876	471	2197
Cocaine hydrochloride (powder)	27	65	563	655
Freebase (crack) cocaine	45	38	52	135

* The individual numbers by type of cocaine used exceed the total number of cases because some cases used both cocaine powder and crack cocaine. For example, 13 cases in 2006 reported using both types of cocaine.

ROSIE data

Findings from a recent national longitudinal drug-treatment outcome study (ROSIE) also suggest crack use among opiate users (Cox *et al.* 2006). The ROSIE study recorded the treatment outcomes for 404 opiate users over a three-year period. In the baseline study in 2003/2004, 58% reported having used crack at some point in their lives. Fewer than 15% of the study sample reported using crack cocaine in the 90 days prior to their baseline interview and only 6.7% reported that they were in treatment for their crack use. Of those entering treatment, recent crack use was more commonly reported among males (44%) than females (15%). At the one-year follow-up interview in 2004/2005, 2% reported that they had used crack during the previous 90 days. This indicates that reported crack use had decreased considerably during treatment.

Local survey data

A survey in 2006 of 28 drug-treatment services that sought to assess cocaine use in Dublin communities reported use of crack among clients (CityWide 2006). Ten of the projects surveyed reported that crack cocaine was being used locally but that none of their own clients were users. Five projects were currently working with clients who were using crack. One project reported that there were two houses in their area where crack was being sold and used.

2.5 Crack use in local drugs task force areas

Information from service providers and data from the NDTRS suggest that some drug-treatment services have been aware of small numbers of clients using crack since the late 1990s, but that significant numbers of cases began presenting for treatment only in 2003, mainly in north Dublin. Services in Tallaght, Finglas, Dublin 12 and Clondalkin reported a marked increase in clients presenting with problem crack use from the middle of 2006.

Well I'm here two years and it has been here for two years before that. The last place I worked in there was definitely a problem with it. So, I mean I personally in my work, it's actually been around definitely in the last 10 years, on and off. Maybe not as big a problem as it seems to be the last two, three, four years maybe.

north-inner city, drug-treatment service (September 2007)

The first time crack was brought to our attention in terms of anybody here using it would have been about six months ago. Six to eight months ago I'd say, where two clients... where it was mentioned first off that two particular clients were dabbling at the weekend...

Tallaght, drug-treatment service (October 2007)

But over the last couple of months there has been a major increase in the supply of crack. A lot more organised and structured. Not ... there's not many people doing it [dealing], but the people that are, have it well sewn up you know. It's readily available now... there's a couple of people at the moment in control of the crack and how it's being dispensed through the area. There's a lot of people using it.

Clondalkin, drug-treatment service (October 2007)

At least one drug-treatment service in each of the LDTFs reported clients receiving treatment for crack use. The larger groups of new cases treated for crack cocaine use lived in Clondalkin, the north-inner city, the Northside Partnership area and Tallaght (Table 2.2).

Table 2.2 Number of new cases who lived in Dublin and reported crack cocaine as a problem drug, by task force area of residence, as reported to the NDTRS, 2004 to 2006

LDTF area of residence	New crack cocaine cases	
	Number	%
Other Dublin*	10	28.6
Clondalkin	5	14.3
North-inner city	4	11.4
Northside Partnership	4	11.4
Tallaght	3	8.6
Finglas-Cabra	2	5.7
Ballyfermot	1	2.9
Ballymun	1	2.9
Blanchardstown	1	2.9
Canal Communities	1	2.9
Dublin 12	1	2.9
Dun Laoghaire-Rathdown	1	2.9
South Inner City	1	2.9
Total	35	100.0

*Includes cases who lived in parts of Dublin not designated as task force areas; also includes cases whose electoral division of residence in Dublin was not specified.

In-depth interviews found a similar geographic distribution pattern to that indicated by the NDTRS data. Of the 31 drug-treatment and social services that participated in interviews and focus groups for this study, 24 reported an increase in crack use in their locality. Among these services, crack-using clients represent a small proportion of cases attending treatment services, with numbers per service ranging from 2 to 20 approximately. While at least one service in every LDTF area reported clients presenting with problem crack use, services in Dublin 12, Finglas, Clondalkin, the north-inner city and Ballymun regarded the use and/or availability of crack as a growing issue in their locality:

Like I saw between January and June I would have seen about 50 people. Now, not all of them would be, they would I would say about 30 of them would have been injecting cocaine. And I would say probably 20 of them now have gone on to use crack.

Dublin 12, drug-treatment service (October 2007)

From people who have walked into me probably about 15 but anecdotally probably about 15 or 20 I would say that haven't presented themselves to the service yet.

Finglas, drug-treatment service (October 2007)

I think we'd about 15 people I think 16 people total I think over the last few months ... it's actually 6 that are regular users, and the rest of them they come in every couple of weeks to us.

Ballymun, outreach worker (December 2007)

Respondent 1: *I'd say it's still building I think at the moment.*

Respondent 2: *I would say out of a core group of 50 there would be about 10 to 15 I would imagine... But it's rising; this is only happening over the last few months.*

north-inner city, outreach workers focus group (October 2007)

Seven services had no experience of crack-using clients, and were not in a position to estimate the scale of use in their locality. This in itself may be an indication of limited scale. Services based in the Canal Communities LDTF area had little current experience of crack use among their clients (although it had been an issue for one service in 2005, two years prior to this study). There were contrasting experiences among services based in north-east Dublin, Tallaght, Blanchardstown and Ballyfermot, with some services reporting growing numbers of crack-using clients, and others reporting no clients. However, a number of these drug-treatment services suspected clients were concealing their crack use.¹³

We were asked to monitor the situation ...and we'd heard a few conversations, but until we started actually asking clients that, we had no kind of concrete information ... most of our clients will admit to having used it in the past, but they wouldn't admit to using it now. They'd tell us information about everything but that they're using. You know where they can get it, how much it costs, and how people are kind of cooking it up themselves as such and altering it themselves. So, they're telling us a lot about it, and there's a lot of chat, and talk about it, but they're not actually admitting to doing it themselves.

Ballyfermot, drug-treatment service (December 2007)

They're not actually coming up and saying that they're on crack cocaine. They won't admit to it, if you know what I mean. Like, to the ordinary services. Or even they wouldn't come up and say to me. But you would know by the body language that they're using, you know. But, like, if I was to swear on the Bible I couldn't say that to you because they're not coming forward and saying it.

north-east Dublin, drug-treatment service (October 2007)

Six to eight months ago I'd say, where two clients ... where it was mentioned first off that two particular clients were dabbling at the weekends... Since then intermittently I suppose about another two have mentioned it. And that's about all but anecdotally from other people coming in... I know none of us can put our finger on ... exactly what's going on. And the fear ... there is a fear factor involved in this and people are prepared to talk it up, but I'm certainly not prepared to talk it down... And certainly I do believe that crack is a problem as well. And it's evident in Tallaght without a shadow of a doubt it's evident in Tallaght.

Tallaght, drug-treatment service (October 2007)

¹³ The possible reasons for clients concealing their crack misuse are reported in Section 9.

2.6 Key findings

- In the 2006/2007 general population survey, a very low proportion (0.6%) of adults in Ireland aged 15 to 64 years reported that they had used crack cocaine at some point in their lives. In 2003, the proportion of homeless people who reported having used crack at some point was reasonably high at 19%; 3% had used crack cocaine in the month prior to interview.
- Some drug-treatment services have been aware of small numbers of clients using crack since the late 1990s, but the number of cases presenting for treatment in Dublin began to reach double figures in 2003. Since 2004, treatment services in every local drugs task force area in Dublin have reported at least one case of crack cocaine use among their clients. The larger groups of new cases treated for crack cocaine use between 2004 and 2006 lived in Clondalkin, the north- and south-inner city, the Northside Partnership area and Tallaght. Service providers did not specify the type of cocaine used in the majority of cases reported between 2004 and 2006; this may have resulted in an under-estimation of the number of crack cocaine cases. Of the 790 cases in treatment who specified the type of cocaine used, 135 (17%) used crack cocaine.
- In 2006 crack users accounted for a very small proportion (1%) of drug users in treatment.
- Of the 31 drug-treatment and social services that participated in interviews and focus groups for this study, 24 reported an increase in crack use in their locality.
- Outreach workers also indicated that problematic crack use had increased in recent years.
- Seizures of cocaine have increased steadily and significantly since 2000. Since 1998, crack has not been reported as a separate drug from cocaine in the annual reports of An Garda Síochána. Reports from a crack-specific Garda Síochána operation called Operation Plaza suggested that non-Irish nationals may have provided the initial supply of crack in Dublin.
- In 2003, the Forensic Science Laboratory and the Garda National Drugs Unit (GNDU) undertook a once-off project to screen cocaine seizures for the presence of crack. Of 122 seizure samples tested, only four were found to contain crack cocaine.

3 Dublin crack cocaine market

3.0 Overview

This section outlines the key concepts employed by international criminological research to facilitate an understanding of the organisational structures and dynamics of illicit drug markets. These explanatory models are then used to describe the organisational structure of the Dublin crack market and the supply and distribution of crack in the Dublin region. Information on the marketing techniques employed by crack dealers to sell the drug, and the risk-management strategies used to avoid detection, are then considered. Available evidence on so-called 'crack houses', crack price and purity is then examined.

3.1 Introduction – understanding drug markets

There has been limited research focusing on the illicit drug market in Ireland (Connolly 2005).¹⁴ Understanding the scale, nature and dynamics of the drug market is a critical requirement for effective policy-making and action. In particular, understanding how local drug markets or low-level distribution networks operate and what impact they have on local communities is an important prerequisite for effective interventions such as local policing, harm reduction or housing initiatives (Connolly 2005). The illicit drug market can be understood as incorporating three inter-related dimensions: (i) the 'international market', (ii) the 'middle market' and (iii) the 'local market'. The international market refers to drug production and international trafficking; the middle market involves the importation and wholesale distribution of drugs within a country, and the local market involves retail distribution to drug users (Connolly 2005; Lupton *et al.* 2002; Pearson and Hobbs 2001).

The UK crack market and the people involved are described as operating at three levels (Burgess 2003):

- Level 1: Street markets where street dealers sell crack to users.
- Level 2: Middle markets where suppliers buy from importers or brokers and sell on to street dealers.
- Level 3: Import markets where importers or brokers are involved in large-scale importation of cocaine.

While these distinctions are useful, it should be noted that markets can be fluid, particularly at middle and local levels, and there can be an overlap between markets and the individuals involved. Street dealers may also act as middle-market suppliers.

¹⁴ The HRB's Alcohol and Drug Research Unit (ADRU) is currently conducting a two-year study on the illicit drug market in Ireland. This research is commissioned by the National Advisory Committee on Drugs (NACD) and is due to be completed by the end of 2009.

When describing local drug markets, a further useful distinction has been made between 'open' and 'closed' markets (May and Hough 2004; Burgess 2003). Open markets can be located on the street where dealers will congregate and wait to be approached, or they may be off the street in premises which can be accessed by anyone – locations such as bars, so-called 'crack houses' and pubs. In open markets, dealers will sell to any buyer, even one unknown to them (Burgess 2003; GLADA 2004a). Closed markets can also operate on the street, but dealers will usually arrange by mobile phone to meet a buyer, and will only engage with buyers that they already know or who are introduced to them by a trusted source. Closed markets may operate in premises, but are usually only accessible to users that are known to the drug dealer.

The nature of the market may have considerable implications in terms of community impact, law-enforcement and harm-reduction initiatives. While closed markets are less visible and therefore not as disturbing for the local community, they are far more difficult to detect and monitor (Hough and Natarajan 2000). In Dublin, there have been significant alterations in the nature of many retail drug markets since the mid-1990s (Loughran and McCann 2006). Open drug markets are no longer as common as they were in the late-1980s and 1990s. A significant factor in this alteration has been the emergence of the mobile phone.

Another important feature of crack distribution in the UK and the US is so-called 'crack houses'. The term 'crack house' covers a wide range of buildings where crack cocaine is sold and used (Burgess 2003). These buildings may be residential, semi-derelict or unoccupied. They are often rental or social housing premises (housing association or local authority). In the UK, in addition to providing a social setting for crack users, crack houses may provide users with a 24-hour supply of crack and the opportunity to exchange sex for crack (GLADA 2004a: 16). There are a number of ways in which a building can become a crack house. Dealers will often use violence or intimidation to commandeer a person's home for the purposes of establishing a crack house (Burgess 2003). That person may be in a vulnerable position in that they are already addicted to drugs and dependent to some extent on the dealer. A review in the UK has found that people whose houses have been taken over have at least one of the following attributes: crack or other drug problems, drink problems, mental health problems or learning difficulties; they are likely to be elderly, or young women, often single parents who have some dependency on the dealer, or prostitutes (Burgess 2003). A dealer may also gain access to a person's home under the guise of friendship and a perception by the homeowner of benefits resulting from the use of the house.

The role of prices can also be an important determinant of crack use and an indicator of availability. In the UK, reported crack prices average £18, or €26.75, for a 0.2 gram 'rock' of crack, although the media have reported that rocks of cocaine may also be

sold on the street for as little as £5–£10 (UK Focal Point on Drugs 2007; Goodchild 2005). In the US, a rock of crack cocaine can be sold for as little as \$5, making it much more financially accessible to larger segments of the population (Sterk 1999).

3.2 The organisational structure of the Dublin crack market

Crack dealing in the north-inner city

According to the GNDU, information gained during Operation Plaza indicated that the Dublin crack market was confined to small areas in the north-inner city and west Dublin. Gardaí identified approximately 17 individuals dealing in crack at that time, twelve of these individuals were of West African origin (GNDU, personal communication, 19 May 2006). The GNDU provided the following data for the purposes of this study:

In the North Central Division between January 2005 and December 2007 there were:

- 23 seizures of crack cocaine;
- 23 subsequent crack-related arrests;
- 11 convictions secured in relation to these arrests, with five individuals awaiting sentence; a bench warrant has been issued in three cases for non-appearance in court.

(GNDU, personal communication, 15 January 2008)

The present research confirmed the availability of prepared crack in a popular north-inner city shopping district. Of the 24 services that had treated clients for crack use, 10 confirmed this city-centre location as one where their clients bought the drug, and 5 of the 10 crack users interviewed also identified this area as one of the locations where they purchased crack. Users generally bought the cocaine already prepared rather than preparing it themselves. Although they possessed the skills to prepare crack from cocaine powder, many believed that their dealers, who were primarily of West African origin, prepared higher-quality crack:

Now, don't get me wrong, there's loads of people selling cocaine around the area and that's where they get their freebase from, but they buy their crack cocaine, and I'm not being racist or anything but it's mostly the black¹⁵ men in town in P... Street and all, that's where they're doing it from, that's where mostly the crack is coming from ... and the people down in B... and all them areas.

north-east Dublin, former crack user (October 2007)

15 According to the National Consultative Committee on Racism and Interculturalism (NCCRI) 'some people use the word Black to mean 'of African origin'; whereas others mean 'non-white' and would include people from Asia for example. Black is not generally considered to be a derogatory term and in Ireland, the term 'Black and minority ethnic group(s)' is often used. See www.nccri.ie/pdf/govterminology.pdf

It's rampant out there. It's everywhere now. When I'm going shopping down M... Street. Like every second person you know they are selling it. It's mostly all the foreign nationals¹⁶...

north-inner city, current crack user (October 2007)

One user described the crack market as involving up to 15 dealers, and reported that in a particular shopping centre district there were only 6 main dealers that most crack users would seek to purchase from; within this group of 6, one dealer was described as 'Rock One' and was regarded as having the highest-quality crack:

These are the main 6, like say there is 15 of them, 6 are the main ones but just say, Rock One is the best. Then Rock Three. And then if Rock One wasn't on I would go to Rock Three, do you know what I mean? But there are 6 main dealers...

north-inner city, current crack user (October 2007)

Crack dealing throughout the Dublin region

While the north city centre area was mentioned as the primary market supplying prepared crack cocaine, the findings of this study suggests that prepared crack cocaine is now available outside the north-inner city area. Six users in the study claimed that this was the case. Crack users also expressed the view that the availability of crack outside the city centre was a recent phenomenon – one that had emerged from 2006 onwards. Areas mentioned included Clondalkin, Balbriggan, Ballymun, Coolock and Blanchardstown. In addition, five drug-treatment services confirmed the availability of crack in the Crumlin, Clondalkin, Malahide Road, Balbriggan and Ballymun areas.

Although Garda reports of seizures and arrests were limited to those in the north-inner city, interviews with drug-treatment services personnel also suggest that seizures and arrests have been made outside that area – in Tallaght and Ballymun for example. In the case of Ballymun, drug services reported a perception that these seizures had not been publicised by the gardaí so as to avoid advertising the area as one where prepared crack could be bought.

3.3 Avoiding detection: dealer risk-management strategies

Drug dealers will generally employ a variety of risk-management strategies to avoid being detected by the police. These strategies may include dealing only to people they are familiar with. In response to increased attention and surveillance by gardaí, dealers may take extra precautions, such as directing buyers to different locations in the area to make an exchange. With regard to the inner-city market, a number of users described the scenario of an open crack market where they would often be approached in public by individuals selling crack who were invariably described as non-Irish nationals:

¹⁶ For a discussion as to the use of this term 'foreign national' see www.nccri.ie/pdf/goverterminology.pdf

Like, I was down on M... Street in May this year and I must have been asked three or four times was I looking for crack, was I looking for rocks. Whereas before you had to know where you were going, you had to know who to ask but they were openly asking were you looking for rocks.

Former crack user, unspecified location (October 2007)

I started going into town, up around M... Street like you'd be walking up M... Street and two or three black fellas would stop you before you got from one end to another 'Are you looking for white?' but I never like, you hear lots of horror stories about them ripping and things like that...

north-east Dublin, current crack user (September 2007)

On the other hand, three users outlined the cautious approach to dealing employed by West African dealers in particular.

If you're talking about M... Street ...they'd say ring in 20 minutes and they would ring someone else and another coloured¹⁷ guy would go to that coloured guy and bring it down and cross over. ...And that man is shaking their hand; he is dropping the rock while you're passing the money at the shop doors. It's mad the way it works. Like it's being watched a lot by undercover police. So that's why they meet you offsite now. So, I don't know if they are still doing it... But yeah it's being watched a lot so everybody is wise to that. But if there is no-one kind of around they do all go up and down, straddling around, secretly to anybody.

north-inner city, current crack user (October 2007)

At least one popular dealer based in Dublin city centre would not sell to unknown buyers unless they had been introduced by trusted clients. Contact between dealers and buyers was reported as being maintained in many cases by mobile phone, with specific meeting points arranged for an exchange:

I would say about 15 people come to me to get the stuff... And when I went and met the coloured guy I said to him 'Look, listen' I said. 'Can I introduce one of me friends to you like, this person will be grand and this person will get everybody else's money and you know you can go like to meet them. Wherever you say they will go and they will meet you.' He wasn't having any of it because he's convinced two of the people that are good buyers like myself that they are trying to set him up.

north-east Dublin, current crack user (October 2007)

He'd know me, I'd know him, you know? If I was ringing from a landline, you know I'd say – 'Look, I have money, are you available?' 'Yeah meet me up at...' So, you'd walk up and meet him then, you'd give him the money and if you were on a mobile, more times than not he'd

¹⁷ According to the NCCRI the word 'coloured' is now considered to be a derogatory term in Ireland and many other countries. It was frequently used in the US in the past and was enshrined in law in South Africa during the apartheid era when the term Coloureds was one of the four main racial groups identified by law (Blacks, Whites, Coloureds and Indian). See www.nccri.ie/pdf/govterminology.pdf

walk out of his flat, come down and meet you at a certain spot and the crack would be there on the ground. He'd after being out before you got up there and it'd be under a can, it'd be beside a bin. That he wasn't carrying it down the street in case he got arrested, he'd give you the money – there it's under that, in the bin, it's behind that can, it's under that wheel.

Former crack user, unspecified location (October 2007)

Information regarding distribution outside the city centre was less easy to obtain. However, findings indicate that crack markets operating outside Dublin city centre exhibit closed-market characteristics, i.e. exchanges are arranged using mobile phone contact.

Somebody gave me a number, they told me a young fella ... there's four different young fellas as far as I know, selling rock, up in Ballymun. And somebody gave me a phone number and told me to say, like, I sent you up, so I rang the geezer and said 'what's the story, I'm a friend of such and such, are you doing rock?' And he goes 'yeah, yeah', and said 'I'm going to jump the bus up to you...' So, when I got up and I rang him then, up in Ballymun and he talked me into going to meet him, where I had to meet him.

north-east Dublin, current crack user (October 2007)

It was reported that there is a growing number of local Irish dealers involved in the distribution of crack, especially outside the inner city. Where crack is available locally, there is reportedly only a small number of individuals dealing in the drug who may use young sellers (who may not themselves be users of the drug) or older users to distribute the drug in different communities.

But over the last couple of months there has been a major increase in the supply of crack. A lot more organised and structured. Not ... there's not many people doing it, but the people that are have it well sewn up you know. It's readily available now... There's not many people dealing it, as in control of it. There's a couple of people at the moment in control of the crack and how it's being dispensed through the area...

Clondalkin, drug-treatment service (October 2007)

They were going down to M... Street and going down to Dublin 8. But now over the last I would say three or four weeks, it's being sold in Dublin 12 ... so there is about four people in the community that could be named as a dealer for crack cocaine but as I said it's only in the last few weeks...

Dublin 12, drug-treatment service (October 2007)

3.4 Marketing crack

Four interviewees referred to the 'marketing' of crack by dealers. Marketing tactics include encouraging heroin users to take up crack use by refusing them heroin, citing a 'drought' (lack of availability of heroin at the time), and offering crack. It is also reported that some dealers offer first-time customers (in particular, sex workers) free crack in order to promote their habit:

Well I have asked actually a couple of the girls in the area, who live in this area, who say that they don't have a crack problem but they're constantly being asked do they want it. And when they try and source heroin, they're being offered crack in the absence of heroin. And so, anecdotally, a couple of the girls here, one girl in particular would say that it is beginning to become a problem in that when she's trying to source heroin, she's being offered crack instead.

north-inner city, service provider (November 2007)

Another marketing strategy includes dealing in 'party packs', where crack is sold in combination with other drugs such as heroin, cocaine, ecstasy or cannabis:

They're going around now with party packs with crack, heroin and tablets inside of it, do you know and they are selling them, they are selling them for 50 and 100 quid a go.

north-inner city, service provider (September 2007)

Crack dealers may also target known drug users outside methadone clinics:

But like they are being asked you know a lot of the time they're being offered stuff free and then if they take it free they pay huge amounts of money afterwards for it you know. So, they seem to be targeted, they certainly are targeting people who are known drug users who may not be actively using for some time, and they're just slowly tempted...

north-inner city, drug-treatment service (October 2007)

I was hoping to get off that clinic. I starting cutting myself down on my methadone and they are asking me why... and I was just saying because I felt like it. It was just I want away from where I am. Because like even over at P... Street you can get rock, you're asked 'are you looking for gear, do you want any tablets? Any pills? Do you want any crack? I have lovely powder'. You know you get a pain in your bollocks with it. And I think it's like a big magnet. I really do. I just want away from P... Street. I really do.

north-inner city, current crack user (October 2007)

Dealers may also entice young buyers by marketing crack as 'smokeable' cocaine.

It's also a significant increase in the number of young people that are actually using from as early as – as young as 13, 14. They are smoking it and you know trying to get them wise to it because it is sold to them as coke, it is not sold to them as crack.

north-inner city, service provider (November 2007)

3.5 Crack houses

Five users had availed of, or were aware of, crack houses in their local area or elsewhere in Dublin. The remaining interviewees reported using crack, mostly in their own private location, with crack-using friends. Ten drug-treatment services reported anecdotal knowledge or strong rumours of crack houses in their local area. However, participants in the in-depth interviews described crack houses as places where crack could be used, and in some cases prepared, only in exchange for free crack. They were generally not described as a major source of crack dealing or a base for sex workers, which are common characteristics of crack houses in the UK.

Well, they go to use it mostly rather than buy it. They can buy the coke there but they mostly use. They mostly go outside to buy the crack, but they buy the coke there... So, I'd say in this area, there's probably about two or three of them [crack houses] ... It's a place just to go like, because mostly the people that live in the house. If somebody comes to their house with crack, they get a free shot. So, that's why they're allowing people through their door that have crack. So, they can get freebies like.

north-east Dublin, former crack user (October 2007)

Yeah, I know of three [crack houses]... When you go in Jesus Christ there's bodies everywhere. Everybody's just smoking it. I mean when you walk in you can hardly see there's just smoke, you know... And one of them it's like a closed-up house but it's being used as a crack house you know. Like the police have been up to it a number of times. Put the door in to try and catch people selling stuff and that. A couple of times I think they got a little bit out of it. But they never really got much because the coloured guy was cute, you know what I mean? There was not a lot on him, he hides it and he would get a phone call and he'd know exactly how many [rocks] to bring.

north-inner city, current crack user (October 2007)

One outreach worker drew attention to the vulnerability of young mothers with problematic drug histories who live in social housing. These women are at risk of exploitation because their homes provide an opportunistic location for the use of drugs such as crack cocaine:

The Council have to put up their hand as well and take responsibility. They're getting young girls with kids, who've been in a vulnerable situation, they're giving them homes. And I know they've been there, done that, wore the T-shirt, and they're trying to get their lives together and all of a sudden then they're being exploited then. And one is coming, 'Ah you knew what it was like when you were on drugs, ah just the once' and that once goes on to become an everyday thing.

north-east Dublin, outreach worker (September 2007)

While crack was generally bought already prepared, one treatment service that had experienced a rapid increase in crack cocaine use among its clients reported that users were buying high-quality cocaine and preparing it themselves with ammonia or baking soda (a process known as 'washing up' or 'cooking up'):

So, most people are actually washing it up themselves. I've heard of two houses where people go in and wash up, like they would buy X amount – maybe half an ounce and they would wash it up in these houses and they would be using there for days on end so. So it's ... in a way it's like a crack house nearly ... it's not like an American crack house where it's sold and done there, it's a bit different because basically people would be arrested and stuff like that so it's a bit more kind of informal...

Finglas, drug-treatment service (October 2007)

3.6 Price and purity

Price

The findings presented in this study suggest that the price of crack is relatively stable and uniform. According to six users and six drug-treatment services, prepared crack cocaine is being sold in €50 or €100 quantities or 'rocks'. A €50 rock is generally described as being half the size of a thumbnail, and a user could use a €50 rock for four smokes or pipes. This pricing is higher than the generally reported UK and US street prices described above.

During in-depth interviews, several crack users admitted that the price of crack curtailed their use of it. Unlike heroin, maintaining a crack habit could cost several hundreds of euro a day, or thousands of euro a week. The high achieved from crack use is intense but short-lived (generally described as lasting up to 30 minutes), prompting many users to divert all their available resources to the purchase of the drug. The average weekly spend varied among users in the study depending on their pattern of use and the availability of finances. The range of expenditure reported was from €200 a week up to €11,000 on a two-day binge:

I came into money; two of us came into money, six and a half grand we came into. It was pounds at the time. And we met up with J... and we were staying in at the [hotel] in C... and I'd say £5,000 went on crack; the rest of the money went on drink and heroin... I think it was a long weekend.

Former crack user, unspecified location (October 2007)

About four months ago I spent €11,000 in two nights... I was after getting a claim you know in prison.

Clondalkin, current crack user (September 2007)

I know one lad I think he's on five to six hundred quid of crack and four to five hundred quid of heroin, every day. That's a thousand euro you've to steal every day so he basically has a rucksack on his back and he walks with that 24 hours a day.

north-inner city, outreach services focus group (September 2007)

Crack? Yes we've one individual who went through 120 thousand in a year – obviously a claim and he did it, just smoked it until the cows came home.

Tallaght, drug-treatment service (October 2007)

Purity of crack

In 2003, the Forensic Science Laboratory and the Garda National Drugs Unit (GNDU) undertook a project to screen cocaine seizures for crack. As noted above, out of 122 seizure samples tested, only 4 were found to have contained crack cocaine (Raggett *et al.* 2003) However, as has been also mentioned, purity testing for drugs is not routinely undertaken by the Forensic Science Laboratory. It has been noted that cocaine purity is lower in Ireland than anywhere else in Europe (Connolly 2005). In 2004, the average purity of cocaine analysed was 23%. Forensic analysis of possible crack cocaine seizures could have proven useful to this study.

3.7 Key findings

- Gardaí identified approximately 17 individuals dealing in crack during 2005/2006.
- Despite targeted Garda operations in 2005/2006, the north-inner city remains the primary crack market in Dublin. Of the 24 services that had treated clients for crack use, 10 confirmed a particular north-inner city location as one where their clients bought the drug, and 5 of the 10 crack users interviewed also identified this area as one of the locations where they bought crack.
- According to the data available, prepared crack is also available in Balbriggan, Ballymun, Blanchardstown, Clondalkin, Coolock and Malahide Road since 2006.
- Findings indicate that crack markets operating outside Dublin city centre exhibit closed-market characteristics, i.e. dealers will not sell drugs to strangers and exchanges are likely to be arranged using a mobile phone.
- In response to surveillance by gardaí, a number of inner-city dealers take precautions such as refusing to deal to unknown buyers, arranging exchanges using mobile phone contact only, and directing buyers to specific meeting points outside the inner-city for an exchange.
- It is reported that only a small number crack dealers operating in local areas use young people (who may not themselves be crack users) as sellers or older users to distribute the drug in different communities.

- Although a number of dealers, or clients themselves, possessed the skills to prepare crack from cocaine powder, many users believed that dealers who were primarily of West African origin prepared higher-quality crack.
- The price of crack is relatively stable and uniform. According to six users and six drug-treatment services, prepared crack cocaine is being sold in €50 or €100 quantities or 'rocks'. A €50 rock would yield four smokes or pipes.
- The average weekly amount spent on crack varied among users in the study from €200 in a week to €11,000 on a two-day binge.
- During in-depth interviews, several crack users admitted that the price of crack curtailed their use of it.
- Dealers marketed crack using a number of methods, including selling 'party packs' (where crack is sold in combination with other drugs), targeting drug users outside methadone clinics, and offering heroin users crack instead of heroin.
- Crack houses were referred to as locations where crack could be used, and in some cases prepared in exchange for free crack. Crack houses were not reported as major venues for crack dealing or as sites for sex work.
- Five of the 10 former or current crack users interviewed reported using crack for the first time in the UK or elsewhere in Europe. The increased availability of cocaine in Ireland and the emergence of ready-made crack may have encouraged some users to begin reusing crack cocaine when they returned to this country.

4 Profile of Dublin crack users

4.0 Overview

This section of the report considers international findings which have established profiles of typical crack users (insofar as a 'typical' crack user exists). The profile of crack users in the Dublin region is presented in terms of gender, age, socio-economic background, education levels and accommodation status. This profile is based on NDTRS data, in-depth interviews and focus groups with crack users and service providers, and published surveys.

4.1 Introduction – crack users: 'the marginalised among the marginalised'

In the US, where problematic crack use is centred within deprived inner-city neighbourhoods, users have been described as 'the marginalised among the marginalised' (Fischer and Coghlan 2007: 1340). Problematic crack use in the US continues to be most prevalent among African-Americans and Hispanics (Bourgois 2003b: 32). Similarly, European studies suggest that a large majority of crack users have problematic drug histories and live in socially excluded and deprived communities (EMCDDA 2007a; Drugscope 2005). In the UK, analysis of treatment data has shown the profile of London-based crack users to be slightly different from users of other Class A substances (GLADA 2004c).¹⁸ Crack users were more likely to be younger than heroin users and slightly more likely to be from ethnic minority backgrounds. Frequent users were reported to be more likely to be residing in deprived areas.

However, treatment data can provide profile information only on individuals who seek treatment. Such statistics may reflect only how well treatment services are meeting the needs of different groups. Ethnographic research has documented the growing numbers of older opiate users in London who have begun to use crack cocaine (GLADA 2004b). The link between females, sex work and crack use has also been underlined in research (May *et al.* 1999; Ward *et al.* 2000). May and colleagues interviewed 67 sex workers in three different sites and nearly all had used crack cocaine in the month before being interviewed. Furthermore, crack cocaine accounted for over two-thirds of their expenditure on drugs (May *et al.* 1999).

18 The UK's Misuse of Drugs Act 1971 divides controlled substances into three classes (A, B, C), with A being the most dangerous. These classes provide a basis for attributing penalties for offences. See <http://eldd.emcdda.europa> for further information on European drug laws.

4.2 Crack use and gender

According to the NDTRS, of the 35 new cases who lived in Dublin and reported crack cocaine as a problem drug between 2004 and 2006, 25 (71.4%) were male. The data from ROSIE reported that 75% of the 49 crack users participating in their study were male (Cox *et al.* 2006). However, interviews with drug-treatment and social services personnel did not suggest that crack users were predominantly male or female; the gender balance varied from service to service.

Several drug-treatment services observed that those who were developing the most chaotic crack addiction were females involved in sex work and single mothers. Of the 31 drug-treatment and social services that participated in the study, 8 reported that not only had female former heroin users returned to prostitution to feed a new crack habit but many of these users had entered prostitution for the first time. One crack user confirmed that she was currently involved in sex work. Two treatment services reported that in their experience females, and particularly single mothers, were more likely to develop severe crack addictions:

The [gender] breakdown would have been always about 50/50 of those using crack and cocaine ... but those who developed the really bad problems with crack and with cocaine are single parents, single mothers.

Canal Communities, drug-treatment service (September 2007)

It was the fellas that were slipping to the crack cocaine. I would be well aware of the fellas but I was more shocked because the girls get on it like ... but the difference was you would see the way it devastated her.

north-east Dublin, drug-treatment service (September 2007)

4.3 Crack use and age

The data from the NDTRS provide a profile of 35 new cases who lived in Dublin and reported crack cocaine as a problem drug between 2004 and 2006. Over half (51%) were aged between 20 and 29 years at the time they commenced treatment (Table 4.1).

Table 4.1 Number of new cases who lived in Dublin reported crack cocaine as a problem drug, by age commenced treatment, as reported to the NDTRS, 2004 to 2006

Age commenced treatment, in years	Number	%
10–19	2	5.7
20–29	18	51.4
30–39	13	37.1
40–88	2	5.7
Total	35	100.0

Views expressed by representatives of individual drug-treatment centres and representatives of the social services interviewed for this study suggest that the majority of crack users known to drug-treatment services are relatively older and have a history of problematic use of a number of drugs, which in most cases includes heroin.

It's not a drug that we have seen spread to the wider community, as I said. There is polydrug use there involved with it and a lot of older addicts who possibly would have been off heroin and on methadone have possibly slipped back into that, you know.

north-inner city, Garda member

I suppose the main users that we are seeing coming through using the cocaine and the crack are ex-opiate users and the majority of them would be on maintenance programmes from the clinic.

Clondalkin, drug-treatment service

4.4 Crack use among young people

While a substantial proportion of problematic crack users seeking treatment may be aged 25 years or over, there is evidence that crack is used by younger people. The NDTRS reports that of the 35 new cases reported between 2004 and 2006, 37% (13) had begun using crack cocaine before the age of 20 (Table 4.2).

Table 4.2 Number (%) of new cases who lived in Dublin and reported crack cocaine as a problem drug, by age commenced use, as reported to the NDTRS, 2004 to 2006

Age commenced use, in years	Number	%
12–19	13	37.1
20–29	18	51.4
30–34	1	2.9
Not recorded	3	8.6
Total	35	100.0

A small number of drug-treatment service personnel and crack users reported anecdotal or second-hand evidence of use among young people. In one area, people in their mid- to late-teens were reportedly involved in selling amounts for local dealers and being paid partly in crack:

From about 16 to 21 I would say – they would be using crack so. But again it's sporadic it's kind of binge stuff as well like, they would be dealing and stuff and they would have people who would be doing crack showing them to wash up and stuff... Some young people in this area would see it as attractive you know because older people were doing it.

Finglas, drug-treatment service (October 2007)

There was a perception that younger teenagers were not aware of the harmful nature of crack, and that its 'smokeable' form may give the substance a relatively harmless image:

We feel that crack cocaine, the kids are smoking it like hash. Rolling it up in a cigarette and smoking it but to them it's not coke. You are trying to educate a young group it is a very, I suppose undereducated peer group – and they think we're off our trolley telling them all this...

north-inner city, drug-treatment service (August, 2007)

When we discussed a thing on Monday they said a lot of youngsters would also have crystal cocaine as well for smoking, you know that kind of way. That's not crack cocaine but there's a kind of a ... it's kind of baked into a crystal you know, it's freebase you know...And even at that ... they sometimes think that they're using crack cocaine, some of the younger ones, and they will tell you they're using crack cocaine, and in actual fact sometimes it's not, sometimes it is.

Ballymun, drug-treatment service (December 2007)

Three crack users interviewed indicated that young people in their locality were using crack cocaine:

But the crack then came on the scene and it's a big thing now. You know? Especially now in these areas, and the sad thing about it is they're only kids, you know, they're only 15-year-olds, 16-year-olds coming up to you selling it to you, you know. And then using it themselves and smoking it themselves. You know. It's sad like you know to see them being so young selling it and that. You know.

Clondalkin, current crack user (September 2007)

I'm after noticing a lot like, three or four young fellas that I never thought... I don't think they realise that smoking crack is every bit as harmful as injecting coke or heroin or anything like that. And they're kind of treating it as 'I'd sniff a half ounce in a weekend, me nose is in bits, I'm bleeding on a Monday morning and all this stuff... Jaysus just smoke it'.

north-east Dublin, former crack user (October 2007)

A number of service providers said that they were aware that there may be a proportion of younger, non-opiate-using crack cocaine users who binge on crack cocaine but do not engage with treatment services, primarily because they do not view their use as problematic and/or do not wish to be associated with the established centres that have traditionally treated heroin addiction:

But we know that we have a problem engaging with young people or young people have a problem engaging with us because they are not at that stage, you know they are not at that stage of seeing it as a problem or whatever so...

Finglas, drug-treatment service (October 2007)

There's certainly a group of people doing crack that are not on methadone right, but we only have rumours. We don't have any definite evidence that this is the case, and they're all reasonably young. You know late-teens, early-twenties at the most.

Tallaght, drug-treatment service (October 2007)

4.5 Education levels among crack users

Evidence of education levels among crack users was available from the NDTRS. Education levels in this group were low, with only three new cases having completed their Leaving Certificate or having attained a higher qualification (Table 4.3).

Table 4.3 Number of new cases who lived in Dublin and reported crack cocaine as a problem drug, by highest level of education completed, as reported to the NDTRS, 2004 to 2006

Highest level of education completed	Number	%
Never went to school	1	2.9
Primary level incomplete	1	2.9
Primary level	8	22.9
Junior Certificate	14	40.0
Leaving Certificate	2	5.7
Third level	1	2.9
Not known	8	22.9
Total	35	100.0

4.6 Accommodation status of crack users

As noted above, the proportion of homeless people (in 2003) who reported having used crack at some point in their life was reasonably high (Lawless and Corr 2005). Data from the NDTRS indicate that over one-third of new cases in the period 2004 to 2006 were living in unstable accommodation (Table 4.4).

Table 4.4 Number of new cases who lived in Dublin and reported crack cocaine as a problem drug, by accommodation status, as reported to the NDTRS, 2004 to 2006

Accommodation status	Number	%
Stable accommodation	21	60.0
Unstable accommodation*	12	34.4
Not known	2	5.7
Total	35	100.0

* Unstable accommodation includes prisons, halfway houses, homeless hostels, bed and breakfast, sleeping rough and living with friends on a temporary basis.

Of the 24 drug-treatment and social services interviewed who that had recent experience of crack users, 16 had experience with homeless individuals using crack. A similar experience was reported by a drug-treatment service specifically targeting the homeless in the north-inner city; it estimated that just under one-third of its clients were using crack (15 users approximately).

4.7 Key findings

- The majority of crack users seeking treatment had a history of problematic drug use (mainly involving opiates). This was confirmed by data from drug-treatment and social services.
- The data from the NDTRS provide a profile of the 35 new cases who lived in Dublin and reported crack cocaine as a problem drug between 2004 and 2006. Over half (51%) were aged between 20 and 29 years at the time they commenced treatment; 37.1% were over 30 years of age; and 37% had begun to use crack before the age of 20.
- According to collated data from treatment settings, approximately three out of every four crack users are male. Interviews with drug-treatment and social services suggested that the gender balance varied between individual services.
- Several drug-treatment services reported that females involved in sex work and single mothers developed the most chaotic crack addiction.
- A number of service providers reported that a proportion of crack cocaine users may be young people who binge on crack but do not engage with treatment services, primarily because they do not view crack as harmful or their use as problematic or do not want to be associated with the established opiate treatment centres. None of these young people were available for interview.
- Education levels were low among crack users in treatment and homelessness was common

5 Patterns of crack use and routes of administration

5.0 Overview

This section outlines common patterns of crack cocaine use as well as routes of administration that have been reported in international studies. It also presents findings from NDTRS data and from the in-depth interviews and focus groups with users and service providers in relation to the use of crack with other substances, the frequency of use and how crack is administered by users in Dublin.

5.1 Introduction

Research evidence from the UK indicates that the majority of crack users in Britain are polydrug users, and dependent users of heroin in particular (Home Office 2002). A study by Gossop *et al.* (2002) found that some heroin users who were not using crack prior to treatment switched to crack on completion of, or during, their treatment. People receiving methadone treatment for heroin addiction may begin using crack to give them a high while failing to recognise that their use of crack is problematic (Turning Point 2005). Alternatively, crack cocaine users may start to use heroin in order to manage the adverse effects of crack and reduce their withdrawal symptoms (Turning Point 2005). It has been estimated that a substantial part of the growth of crack cocaine use in London was due to its adoption by opiate users, coupled with a growth in opiate use (GLADA 2004a). Heavy alcohol consumption has also been linked to crack use, and UK reports document how street drinkers have begun to use crack (Strange and McGauley 2004). Similarly, US studies have highlighted heroin addiction as a likely path to crack cocaine abuse and Sterk's (1999) ethnographic study of 149 crack-using mothers found that intravenous cocaine use was often a precursor to their crack habit; these women had abandoned intravenous use because their veins were damaged.

Crack is usually smoked using a pipe, glass tube, plastic bottle or piece of tinfoil (GLADAa). It can also be used intravenously by preparing the solid rocks of crack cocaine with a transforming agent such as lemon juice or vinegar, and by applying heat to the mixture. It has been suggested that injecting crack cocaine has remained a relatively hidden practice because many drug-treatment service providers do not specifically question crack users on their modes of administering the drug (Lankenau *et al.* 2004).

5.2 Crack and other drugs

Many of the international findings discussed above emphasise that the majority of crack users have a history of problematic drug use (involving opiates in particular). The findings were borne out by this study. The NDTRS data show that individual cases may report using up to four problem drugs comprising one main problem drug and up to three additional problem drugs. As reported in Section 2.4, there were 135 cases that lived in Dublin and reported crack cocaine as a problem drug between 2004 and 2006. Of these 135 cases, 35 (26%) were being treated for the first time (Table 5.1).

Table 5.1 Number of cases who lived in Dublin and were treated for problem crack cocaine use, by treatment status, as reported to the NDTRS, 2004 to 2006

Treatment status	Year treated			Total
	2004	2005	2006	
New cases	9	12	14	35
Previously treated cases	34	26	34	94
Treatment status unknown	2	0	4	6
Total	45	38	52	135

Eighteen cases reported crack cocaine as their main problem substance. Of these, nine had been treated previously, and eight were entering treatment for the first time (Table 5.2). Fourteen (78%) used more than one drug (Table 5.2 and Figure 5.1). The more common additional drugs were opiates or cocaine powder.

Table 5.2 Number of cases who lived in Dublin and were treated for crack cocaine as a main problem drug, by treatment status, as reported to the NDTRS, 2004 to 2006

Crack cocaine main problem drug by treatment status	Year treated			Total
	2004	2005	2006	
New cases	1	2	5	8
Previously treated cases	3	2	4	9
Treatment status unknown	0	0	1	1
Total	4	4	10	18

There were 117 cases who lived in Dublin and were treated for problem crack cocaine use as an additional problem drug between 2004 and 2006. Of these cases, 85 (73%) had been previously treated for problem drug use and only 27 (23%) were entering treatment for the first time (Table 5.3).

Table 5.3 Number of cases who lived in Dublin and were treated for crack cocaine as an additional problem drug, by treatment status, as reported to the NDTRS, 2004 to 2006

Crack cocaine as an additional problem drug by treatment status	Year treated			Total
	2004	2005	2006	
New cases	8	10	9	27
Previously treated cases	31	24	30	85
Treatment status unknown	2	0	3	5
Total	41	34	42	117

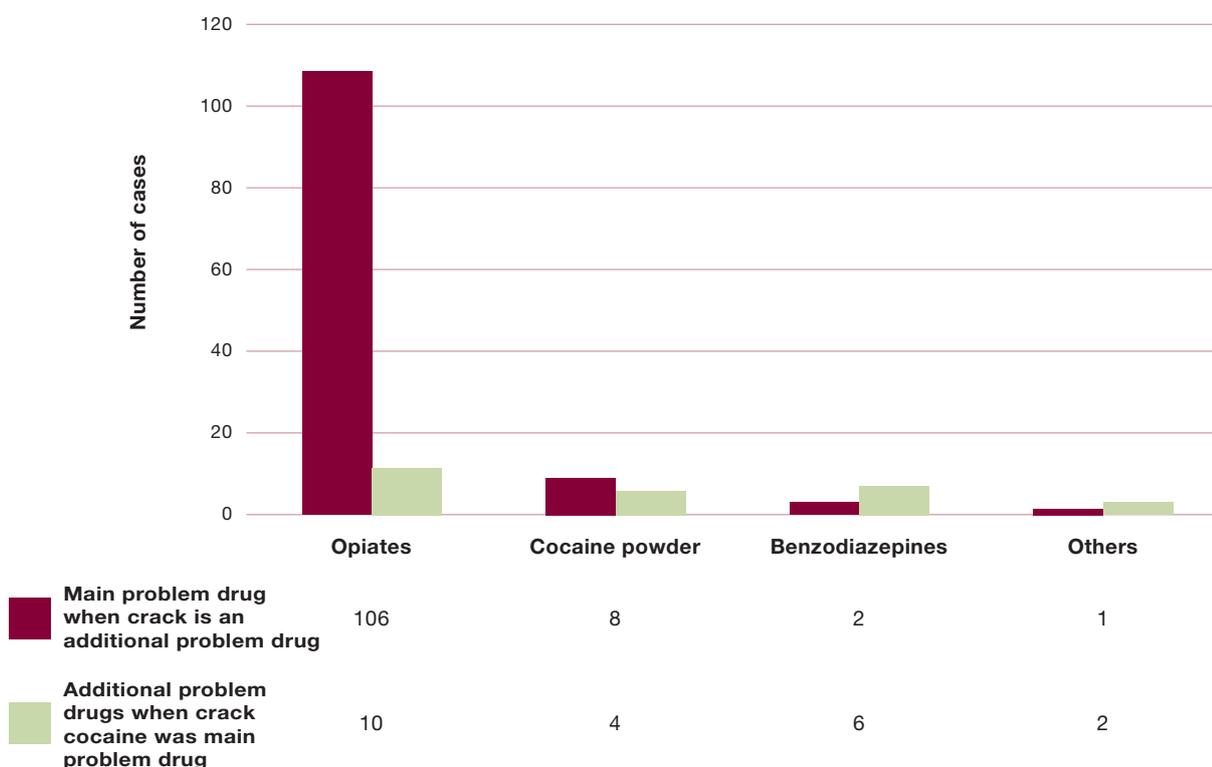


Figure 5.1 Number of cases who lived in Dublin and were treated for crack cocaine, by other types of problem drugs used alongside it, as reported to the NDTRS, 2004 to 2006

5.3 Crack and opiates

According to NDTRS data, of the 117 cases who reported crack cocaine as an additional problem substance between 2004 and 2006, 91% reported an opiate (mainly heroin) as the main problem substance (Figure 5.1).

Whether treated cases reported crack cocaine as their main problem drug or as an additional problem drug, it appears that, among these cases, there is a link between crack cocaine use and opiate use. This link may be due to the fact that these cases live in Dublin where the most common treatment option available is methadone substitution.

Interviews and focus groups with drug treatment and social services highlighted that older heroin and methadone users represented the majority of their crack-using clients:

The profile that we have come across that would be using crack would be already on methadone or in recovery for heroin. You know the majority that would be kind of chaotically using ...would have been in addiction in some shape or form previously.

Crumlin, drug-treatment service (October 2007)

Some would be just cocaine users, and then smoking crack, but you would, you'd have the old you know, people stable on methadone and then going onto you know, washing crack and smoking that you know. But it's definitely creating a problem out there.

Blanchardstown, drug-treatment service (October 2007)

The majority would be methadone, they're in clinics, they are getting tested, supposedly getting tested for urines but...

Finglas, drug-treatment service (October 2007)

Crack use may also prompt users to either start or return to heroin use. Heroin may help users to cope with the after-effects of crack cocaine use (such as paranoia and depression). Two drug-treatment services with growing numbers of crack-using clients referred to an increase in the use of heroin or tranquillisers, such as benzodiazepines, by these clients.

Just the burn out on it is too high, that financially wise they can't keep on going with it which probably results in dipping back into injecting heroin again. Which a lot of them hadn't done in a long, long time. They'd moved away from that. But to come down off the coke, to come down off the crack, it increases other drug use as well, increases the Benzo use.

Clondalkin, drug-treatment service (October 2007)

A couple of years ago for methadone treatment there was no waiting list, now there is. Because what's happening is a lot of them are kind of starting to use heroin to come down. And then they are developing another addiction there. So, they are looking for treatment for the heroin addiction or Benzos and alcohol as well.

Crumlin, drug-treatment service (October 2007)

Many of these relatively older users might have first sampled crack cocaine abroad and might have subsequently ceased using it in Ireland due to lack of supply or poor cocaine purity. During the in-depth interviews, 5 of the 10 former or current crack users interviewed reported using crack for the first time in the UK or Europe. The increased availability of cocaine in Ireland, and the emergence of ready-made crack, may have encouraged some users to begin reusing crack cocaine.

5.4 Crack cocaine and powder cocaine

Data from the NDTRS indicates that powder cocaine is more commonly reported as a problem drug than is the case with crack cocaine. Twelve cases reported use of both forms of cocaine. Drug-treatment and social services personnel who participated in this study indicated that, while the use of powder cocaine was their biggest concern (in addition to heroin), recreational powder cocaine users rarely make the transition to crack cocaine. Among recreational users of powder cocaine, crack was generally regarded in a negative manner. The negative media reports that crack has received in the UK and the US appear to have imbued the substance with a 'dirty' or 'taboo' image of hardcore addiction and deprivation; this may repel the majority of recreational cocaine users from experimenting with crack.

We'd have a younger age group that would be attending the centre down to cocaine use. And they're adamant that they wouldn't do crack. They would view crack as dirty.

Clondalkin, drug-treatment service (October 2007)

What you call normal coke users, weekend users – it would be seen as dirty, they wouldn't do it, it's anti-social, it's a 'junkie' thing.

Finglas, drug-treatment service (October 2007)

It's the old heroin. Now within drug users and the kind of peer structure it used to be – well if you inject you're a junkie ... but if you only snort it or you skinpop [to inject a drug beneath the skin rather than into a vein] it well then, you know, at least you're not mainlining [injecting] it into your vein. So crack is kind of the new low, if you like.

Ballyfermot, drug-treatment service (October 2007)

5.5 Crack and intravenous cocaine use

While there is little evidence to suggest that intranasal users of powder cocaine make a transition to crack, interviews with crack users and service providers suggest that a proportion of crack users may make a transition from intravenous powder cocaine use to crack use. Intravenous powder cocaine users may develop crack cocaine habits because of their deteriorating physical condition after a prolonged period of injecting cocaine; problems may include damaged veins, abscesses and amputations. In most

cases of intravenous cocaine use, the user is a current or former heroin user. In the in-depth interviews, three of the services consulted reported that intravenous cocaine use was a precursor to the client's crack cocaine use:

Like I saw between January and June I would have seen about 50 people. Now, not all of them would be, there would I would say be about 30 of them who would have been injecting cocaine. And I would say probably 20 of them now have gone on to use crack. Because they have just realised you know it is a waste trying to inject cocaine now. Their veins are that bad and their abscesses and ulcers and they are that bad. And they are getting the same effect from smoking crack as they would from mainlining cocaine.

Dublin 12, drug-treatment service (October 2007)

Five of the ten users interviewed as part of the study had been using cocaine intravenously before they made a transition to crack cocaine:

See a lot around the area started using the coke, injecting, and they were running out of veins and things were happening, they were getting blood clots like myself and they either stopped or they still wanted the same rush. So, then they turned to the crack for the same rush.

north-east Dublin, current crack user (October 2007)

So I ended up coming home and the usual I was strung out on coke for a long time, injecting coke and my veins started going and I was finding it harder and harder and I wouldn't use my groin... So I started hearing then that it was very easy to get crack, either freebase which like would be just powder form, and you'd rock it up yourself like.

north-east Dublin, former crack user (October 2007)

The evidence suggests that the typical crack user profile in Dublin is that of an opiate-dependent polydrug user. This finding is consistent with the international literature. However, some caution should be exercised in relation to this finding. Many crack users are known to treatment services because they are on methadone treatment programmes for their opiate use. It is important to bear in mind that a population of non-opiate-dependent crack users may exist outside the knowledge of services that primarily cater for the needs of opiate users.

5.6 Routes of administration

Evidence from a variety of sources suggests that crack cocaine is predominantly smoked but that a small minority use it intravenously. The pilot study of the National Drug Trend Monitoring System found that of the participating trend monitors who confirmed the use of crack in their locality, 69% (36) of service providers reported that the main method of administration was by smoking, 12% (6) of service providers reported the main method as injecting, and 6% (3) reported that their clients used both modes of administration (NACD 2007).

Evidence from the in-depth interviews and focus groups and the NDTRS suggests that the majority of users smoke crack. The NDTRS confirms that 27 (77%) of new cases reported smoking crack cocaine and 3 (8.6%) reported using it intravenously (Table 5.4).

Table 5.4 Route of administration of crack cocaine reported by new cases in the month prior to treatment, 2004 to 2006

Route of administration	Number	%
Smoking	27	77.1
Injecting	3	8.6
Not known	5	14.3
Total	35	100.0

The most common equipment used for smoking crack included plastic bottles and cans pierced with makeshift tubes, such as the barrel of a plastic pen. Old inhalers, previously employed to treat respiratory problems such as asthma, may also be used to smoke it.

You get a plastic bottle, you put a little bit of tinfoil around the top, put little holes in the top of it, put a bit of ash on it, crack on the top of it and you stick the barrel of a pen in it and that's just, you know you set fire to the top, you just suck the smoke out of the bottle, because that's all you need is the smoke ... and they could use in any lane and do that, they don't need to be in a house, it only takes two minutes to do.

north-east Dublin, current crack user (October 2007)

Four services reported having clients who injected crack intravenously. Two services did not know that it was possible to inject crack. Only one crack user in the study sample had injected it intravenously. However, former intravenous users of powder cocaine progressed to crack use because they could no longer use needles due to the abscesses they had developed. Therefore, intravenous injection of crack was not a viable route of administration for many users.

5.7 Frequency of use

Eight of the 35 new cases reported to the NDTRS used crack cocaine on a daily basis; an additional 5 cases used it between two and six times a week (Table 5.5). A significant minority of treated crack users had not used the drug in the month prior to their treatment.

Table 5.5 Number (%) of new cases who lived in Dublin and reported crack cocaine as a problem drug, by frequency of use, as reported to the NDTRS, 2004 to 2006

Use in the month prior to treatment	Number	%
Daily	8	22.9
2–6 days a week	5	14.3
Once a week or less	3	8.6
No use in past month	16	45.7
Not known	3	8.6
Total	35	100.0

The data from in-depth interviews indicated a similar pattern. Binge use was the predominant pattern, but a number of clients reported sustaining a daily habit. Binges could vary from a single, intense one day session to a longer session lasting up to five days, depending on a user's finances. While some drug-treatment personnel reported the rapid onset of addiction in certain clients, they also made the point that a number of clients use crack sporadically or opportunistically rather than compulsively. Not every client was a compulsive user, even if they did have a problematic drug history.

For some it's binge-like around pay day and the weekend but for a few it is daily and that's all they'd use. Those who are bingeing would be using other things in between.

north-inner city, drug-treatment service (September 2007)

For some it is just occasional, you know and they'll go on a bit of a bender and they'll pull back from it, and they mightn't go near it again for a month or two months. And for others it becomes a lot more consistent...

Clondalkin, drug-treatment service (October 2007)

Among the study's sample of users there was also a degree of variation in relation to their pattern of use. Five of the 10 users interviewed had been or were currently using crack on a daily basis, and three were currently using it once or twice a week (usually when they received their social welfare payment). These users admitted that they would use more if they had greater resources available to them. The remaining former users had smoked crack only sporadically.

I'd smoke every Wednesday and Friday, and I'd smoke four bags... I kind of try and make it last.

north-east Dublin, current crack user (September 2007)

I knocked it on the head but I have the slip at the weekend. Like, if I had more money I would do it. But I was locked up loads of times in Mountjoy.

north-east Dublin, current crack user (October 2007)

5.8 Key findings

- Of the 135 cases treated for problem crack cocaine use between 20004 and 2006, 18 reported crack cocaine as a main problem drug and 117 cases reported it as an additional problem drug.
- According to NDTRS data, of the 18 cases who reported crack cocaine as a main problem drug, 10 reported an opiate (mainly heroin) as an additional problem drug. Of the 117 cases who reported crack cocaine as an additional problem drug, 91% reported an opiate as the main problem drug.
- Information obtained in the in-depth interviews suggests that crack use may encourage the use or reuse of substances such as heroin, benzodiazepines or other tablets in order to manage the side effects of crack, such as anxiety or depression.
- Among recreational users of powder cocaine, crack was generally regarded in a negative manner. Recreational users of powder cocaine, who administer it intranasally (by sniffing), rarely made the transition to crack cocaine.
- A proportion of intravenous powder cocaine users made a transition to smoking crack cocaine because of the physical harms of injecting powder cocaine (such as abscesses and damaged veins).
- Smoking was the predominant mode of administration of crack cocaine, but intravenous use is preferred by a small minority. A small number of services were unaware that crack could be used intravenously.
- Eight of the 35 new cases reported to the NDTRS used crack cocaine on a daily basis, and an additional five cases used it between two and six times a week. Five of the ten users interviewed had been or were currently using crack on a daily basis, and three were currently using it once or twice a week (usually when they received their social welfare payment). These users admitted that they would use more crack if they had greater financial resources available to them.
- While some drug-treatment personnel reported the rapid onset of addiction in certain clients, they also pointed out that a number of clients used crack only sporadically or opportunistically, rather than compulsively. Even among clients with a history of problematic use of other drugs, not all were compulsive users of crack.

Part 3

Consequences of crack use

6 Crack-related crime

6.0 Overview

The association between drug use and crime in the international literature is generally considered using four explanatory causal models – (i) psycho-pharmacological crime, (ii) economic compulsive crime, (iii) systemic crime and (iv) the common cause model. This section employs these models to outline the main findings from international research on crack-related crime. Drawing on information supplied by crack users and service providers, it presents findings on the association between crack use and crime in Dublin. The incidence of violent crime and acquisitive crimes such as theft, prostitution and drug dealing are also considered.

6.1 Introduction: the drugs–crime linkage

The classification of drugs and precursors in Ireland is made in accordance with the three United Nations conventions of 1961, 1971 and 1988; these introduced controls in relation to legitimate scientific or medical use of drugs and precursors that also take into account the particular risks to public or individual health.¹⁹ Irish legislation defines as criminal offences the importation, manufacture, trade in and possession, other than by prescription, of most psychoactive substances. The principal criminal legislative framework is laid out in the Misuse of Drugs Acts (MDA) 1977 and 1984 and the Misuse of Drugs Regulations 1988. The offences of drug possession (s.3 MDA) and possession for the purpose of supply (s.15 MDA) are the principal forms of criminal charge used in the prosecution of drug offences. Prior to 2006, data on drug offences were reported in the annual reports of An Garda Síochána, but this is now the responsibility of the Central Statistics Office. The Misuse of Drugs Regulations 1988 list the various substances to which the laws apply under five schedules.

However, most Irish drug users who receive sentences of imprisonment are punished, not for drug offences *per se*, but for offences committed as a consequence of their drug use (Connolly 2006a). Although research studies have identified the clear link between some forms of illicit drug use and crime – findings that are consistent throughout criminological literature – identifying the precise nature of this link is more complex (Stevens *et al.* 2005; Bean 2002; White and Gorman 2000). Identifying the causative connection between drugs and crime has been a primary preoccupation of many writers in this area.

For the purpose of this study, we will examine the link between crack cocaine and crime, using the four explanatory causal models outlined above. The first three models follow classification by Goldstein (1985) and are generally used to explain links

¹⁹ For relevant Irish and international legislation, see the European Legal Database on Drugs which is maintained by the EMCDDA at <http://eldd.emcdda.eu.int/>

between heroin, cocaine and crime. The fourth model views drug-related crime as resulting from a combination of influences or 'common causes'.

Psycho-pharmacological: The link between drugs and crime arises as a result of the psycho-pharmacological properties of the drugs themselves. This model proposes that the effects of intoxication cause criminal (especially violent) behaviour, or that aggression and crime can be caused by, for example, the effects of withdrawal or sleep deprivation.

Economic-compulsive: The economic model assumes that drug users need to generate illicit income from crimes such as robbery and burglary, and from consensual crimes such as prostitution, in order to support their drug habit.

Systemic: The systemic model explains drug-related crime as resulting from activities associated with the illegal drug market. Systemic types of crime surrounding drug distribution include, for example, fights over organisational and territorial issues and disputes over transactions or debt collection. Associated third-party violence can include injuries to bystanders. Also included in this model are drug-related crimes and nuisance and the fears of victimisation which can become associated with local drug markets.

Common cause: The common cause model holds that drug use and crime do not have a direct causal link but that they are related because they share common causes. For example, as Hough *et al.* (2000: 2) suggest, 'economic deprivation, inconsistent parenting, low educational achievement and limited employment prospects are risk factors not only for chaotic or dependent drug use but also for heavy involvement in crime'. Drug use can speed up the rate of offending but offending is not necessarily caused by drugs, as criminal activity often predates drug use (Pudney 2002).

Crack use and crime

In recent years, some US academics have been critical of the supposed strong link between crack use and crime, particularly violent crime. Reinerman and Levine (2004) argue that crack-related crime is a function of illicit market systems in deprived impoverished areas, and not necessarily a direct consequence of the psycho-pharmacological properties of crack on the human brain. Morgan and Zimmer (1997) suggest that, among people predisposed to behaving violently, crack, like any form of cocaine, may increase the likelihood of their involvement in violent episodes. Research also suggests that when a person is involved in long-term crack cocaine use, their involvement in crime is likely to escalate and they are more likely to be involved in violent crime (Haropocos *et al.* 2003; Parker and Bottomley 1996; Brain *et al.* 1998; Gossop *et al.* 2002).

With regard to crack use and acquisitive crime, it was found in the UK that crack users reported the highest levels of drug expenditure and the most crime (Best *et al.* 2001). Prostitution is another source of income availed of by drug users, particularly females, to sustain their drug habit. Studies of English cities and towns have indicated the prevalence of crack use among female sex workers, particularly street-based workers, who in many cases spend the majority of their earnings on crack (Jeal and Salsbury 2007; Terence Higgins Trust 2006; Ward *et al.* 2000). While there has been no research related specifically to crack cocaine in Ireland, O'Neill and O'Connor (1999) found that female prostitutes who were drug users engaged in sex work purely to sustain their drug habit. Dillon (2001: 41) found that female inmates in an Irish prison who had been involved in sex work were 'reluctant criminals' and they pursued sex work because it was deemed low risk when compared with larceny or burglary.

With regard to systemic-type crimes, studies based in New York and London have documented the manner in which young people in deprived communities become involved in dealing crack (Bourgois 2003a; Lupton *et al.* 2002). No research studies have been conducted in Ireland on this subject. Available evidence, which includes newspaper and court reports, does suggest that there is a significant and increasing amount of violence associated with the illegal trade in drugs. In a number of recently reported seizures in Ireland, guns were discovered along with the drugs (Connolly 2006a).

6.2 Psycho-pharmacological crime: crack and violence

The majority of drug-treatment services reported that crack-using clients exhibited a higher degree of aggressiveness when they presented for treatment. However, no drug-treatment personnel reported any level of violent encounter with users, and a large majority of those interviewed stated that they had no fears or reservations about treating crack users, despite the higher levels of aggression or tension:

And I was in another family setting the other day and [she] is causing chaos and they said that it's the aggression, the attacking, they don't give a fuck like, that's what the daughter said to the ma that [she doesn't] give a fuck like. And the ma said 'but we've come so far, you've got so far, you got stabilisation back, you got working relations with your family with your own kids and now all of a sudden it's all about to go out the window'. And she's prepared to throw it out, and if she throws it out well that's the way it's going to go, friends will take them in for a while but they won't take them in for long.

north-east Dublin outreach worker (October 2007)

So, they would talk about the kind of violence in their outside life. But even when they are in here they are more aggressive. They do, everything they do, they do it aggressively. You know even when they are talking. Their speech is aggressive. You know their body language is aggressive and they kind of you know, if I am sitting there and they are sitting here kind of you know getting closer to you and they are you know, you're slipping your chair back a little bit.

Dublin 12, drug-treatment service (October 2007)

Oh there is, the last one we dealt with, he's living with his auntie and his uncle, and he's bashed his uncle. So, he's ended up homeless through it, so there are consequences for them.

Location anonymised, drug-treatment service (October 2007)

Two users disclosed details of paranoia-fuelled violent episodes that occurred during a crack binge. Both claimed that they were not normally capable of such behaviour.

I walked into the kitchen ... and I took out a knife. Came out of the kitchen like a fucking lunatic, and went over to yer man, with the knife. I said 'you think I'm a fucking idiot do you?' And he was looking at me saying 'P... what's fucking wrong with you?' I said 'What's wrong with me? Yiz are trying to get me out of this fucking house to rob me, that's what yiz are fucking bullshit, do you think I'm fucking thick?' And with that he said 'Ah relax'. Thanks be to God the dog didn't start getting aggressive and barking or copping on. But I started slicing yer man's sofa, and he had this big table and it had all [deletion] design and carved in it. I just started stabbing it into that. He had a lovely stereo and so on and I practically fucking wrecked his flat right?

Location anonymised, former crack user (October 2007)

When you're on crack, it's like you're he-man or she-ra or something. It's like you've got this power. I used to walk down the road and think that, 'Anybody comes near me and that's it' do you know what I mean? I went so bad on the crack one night, I stabbed a girl, I went off my head on it, just because she was looking at me. And I actually went back to my flat and got a knife, and only for it went in her leg, I could have killed that girl. And all because I was so out of my head on crack and all she did was, I walked by her garden and all she did was look at me, that's all she did. And she wasn't being cheeky to me or anything, it was just me on crack, because I was cracked out of my head and I was paranoid to bits. You think everybody is after you, everybody is looking at you, it's just madness, it makes you do some horrible things.

Location anonymised, former crack user (October 2007)

6.3 Economic compulsive crime: crack and acquisitive crime

Crack and theft offences

During the in-depth interviews, 6 of the 10 crack users stated that they had been or were currently involved in committing crimes such as shoplifting, burglary and robbery to sustain their crack cocaine habit. In some cases the stolen goods would be exchanged directly for crack.

You go out shoplifting you know what I mean... It's mainly how I do it anyway you know. Down the country shoplifting or you know... Because all the shops up here I'm known in every one, I can't get into them you know, so I have to go down to Cork sometimes, Galway, Limerick.

OK and would you come back up to Dublin then and buy it?

Ah straight away yeah, straight away. And probably like you know whenever I go out shoplifting I probably know the jeans or nice jackets, nice jumpers, nice shirts and all that, they probably say well look it we'll give you so many rocks for the lot you know what I mean? Or say we'll give you 2/300 pounds and we'll give you eight rocks or whatever, you know that way?

Clondalkin, current crack user (September 2007)

I used to go around shoplifting, I used to rob hotels and rob houses and burglary is something that I would never do in the past, because I remember when we were going on holidays when we were kids we got burgled and it was horrible. And for me then when I was on crack, to go and do it, I used to just block it out of my mind, when I was doing it, because I just knew it was going to get me money for crack.

north-east Dublin, former crack user (October 2007)

Staff in several drug-treatment services were aware of the criminal activities that funded their clients' crack cocaine use.

Most of the fellas are doing it like jump overs... A jump over is jumping over [e.g. a shop counter] and robbing, it's either they are doing shops...It's quick money.

north-east Dublin, outreach worker (September 2007)

I think with two of the girls they have increased their shoplifting in order to be able to fund this and both of them would have stopped a lot of criminal behaviour before their crack relapse. So as a result of that, they've gone back to shoplifting...in order to fund the habit.

north-inner city, training and education programme (November 2007)

Crack and prostitution

Nine services had experience with clients involved in sex work. The majority of these women were former heroin users who were on methadone programmes. Some had returned to prostitution after a period of stability, primarily to feed their crack use. The costs of regular crack use may result in the scenario described by one service provider: 'you either deal (drugs) or deal yourself'.

We have a lot of them gone back now to the prostitution, a lot of them. Now it's not like going out on the streets now, it's going to apartments and you know, people know where to go, there's apartments you go to you do your business and they know where to get their money and if they want their money fast they know exactly where to get it... A lot of them are getting paid for it, a lot of them are getting their money and others are just getting their free crack.

north-east Dublin, outreach worker (September 2007)

OK? They [staff] also said that there's quite a number of young ones who are involved in prostitution, right, like that connection between cocaine and the sex trade. Those in prostitution are using crack, not powder, alright? And they will also be the only ones who will be using heroin problematically.

Canal Communities, drug-treatment service (September 2007)

It was also reported that a number of women who would previously have sustained their heroin habit without using sex work as a source of income were now entering prostitution for the first time because of their crack use:

There would be an increase of females going into prostitution. Where they probably would have maintained heroin use for years and never gone into prostitution but now they are at the stage where the want for it is so bad and the cravings are much kind of scarier than the cravings for heroin. They go into prostitution, it is kind of 'I don't care. As long as I get my money for a rock or 10 rocks or whatever I don't care what I have to do for it'. A lot of them would be working on the streets. And a few of them would be [doing it] in the house or his car.

Crumlin, drug-treatment service (October 2007)

I've noticed like, there's a few girls that I know that's only on crack, say about a year, not even a year and they're already turning to the game. And these girls beforehand you would have never thought like, these are all wealthy, middle-class families, they're well-to-do, they have good schooling. One of their sisters is actually a [profession deleted] and I was, I nearly died, because it's just something that I wouldn't think about, do you know what I mean? I was asking her about it and she was like 'ah Jaysus, it's the crack and all'.

north-east Dublin, former crack user (October 2007)

One of the participating crack users reported that she was currently working in the sex trade. This participant had children and regarded prostitution as a less risky means of income in terms of accruing criminal charges:

I get lay ons [loans] off them or give them stuff to hold. Or go out working [prostitution]. I don't rob – I am not into robbing because if I got caught robbing I would be thinking 'oh me kids'. Do you know what I mean? So, I would be working on and off. I worked a lot when I was strung out on coke. So, I knew how it went. So, I just went down one night and gave out me number to a few people. And I work over the phone rather down on the street don't want to get known by police. I can't afford it with the kids and that. If the clients ring me I will do it. If they don't, I don't bother.

north-inner city, current crack user (October 2007)

Another service had experience with women who were based in apartments; the majority of these women's earnings were paid in crack rather than cash.

When it comes to crack cocaine and that – it is the women who are working [in prostitution] and they are generally coming from all over the city...and we have got them up at the moment in from [County in midlands]. I met there two weeks ago a young girl, 19 years of age, crack head, on the streets... I know one girl ... she was going off to an apartment, working for Eastern Europeans... She was going in on a shift from 12 o'clock and I said you know after how long will it be and she said probably 8 o'clock tonight, depends on whoever is coming in after her. There was three women working there. And they are no longer than a month and they moved to another area. But I mean they get crack cocaine and 20 euro an hour. That's pathetic. You know. So you know, at least on the streets they were getting their money, they are getting whatever for their fix but you know to get as much crack as you want and 20 euro an hour.

north-inner city, drug-treatment service (September 2007)

Crack use and drug dealing

There were few reports from drug-treatment services of users dealing crack to fund their habit. Dealers who were also users were less likely to maintain sufficient profits to sustain their habit, as their addiction could lead them to consume their supply:

Some people would be dealing. That's not easily maintained if somebody is dealing and doing crack. It usually tends to fall apart quite quickly you know. They only last a couple of months before they either smoke it all, everything and the profit and then end up in debt so it tends that that doesn't last too much.

Finglas, drug-treatment service (October 2007)

On the other hand, reports from two services and one user suggested that users may sell other drugs, such as benzodiazepines and methadone, to fund their crack habit. Users could legally obtain such medication through prescriptions from their GPs, and they may also be in a position to obtain multiple prescriptions for tablets such as valium or benzodiazepines by attending more than one GP:

Probably sell a few of me own tablets that are after being prescribed from my clinic. Or I sell my methadone. I am really not into robbing. I am too afraid. Years ago I would have. But now I wouldn't. Too afraid.

north-inner city, current crack user (October 2007)

Yeah, through very illegal mad ways, some addicts are dealing themselves. Stealing, selling tablets ... we would have a couple of clients that are going to five or six doctors and they're getting two months' prescriptions off some of them. So, they are the ways it is being fed. Some are on methadone as well.

Clondalkin, drug-treatment service (October 2007)

One user in the study had previously dealt cocaine to fund a heroin and crack habit:

I started using it regularly in ... I'm talking over six weeks in that it was the only drug that I could manage to use... I robbed a drug dealer in [named town outside Dublin] and I came into a lot of cocaine and I was using it intravenously and washing it up and I had a lot of it there. I didn't need money to steal. I could sell the coke and buy heroin out of it. I would have been heroin dependent, I suppose, the past four years and so I was selling cocaine to buy heroin and using the cocaine that I had to make crack, you know. I could never afford a steady habit of crack cocaine. It's very expensive. It was like a treat, do you know. If it was once or twice a week you were lucky, you know.

Former crack user, unspecified location (October 2007)

Young people dealing crack

Although no drug-treatment services were aware of crack users' dealing, three users stated that young people were selling crack as well as using it.

And the sad thing about it is they're only kids, you know they're only 15-year-olds, 16-year-olds coming up to you selling it to you, you know. And then using it themselves and smoking it themselves. You know. It's sad like you know to see them being so young selling it and that.

Clondalkin, current crack user (September 2007)

There's that much around, like you have every second bleedin' person selling it. You're talking what maybe 14 or 15, I've seen some kids even less, I'd say only about 10, I've seen them smoking it.

Interviewer: And are they from the local area?

Yeah

Interviewer: And how do they do they pay for it, how do they get it?

They just have to go out and rob, do you know what I mean? They're either selling it to support the habit or else they're going out and robbing it but the majority of them is selling it. That's what I'd say to you. There's that much around.

north-inner city, former crack user (October 2007)

6.4 Systemic crime: gangland violence

Eleven participants, including both treatment staff and users, referred to rising incidences of violence in their localities involving violent assaults related to drug debt, gangland violence and fatal shootings. However, it is not clear whether such incidents are related to crack cocaine or to other substances such as powder cocaine or heroin:

Obviously there are dealers here but a lot of people come from outside. They come like next to... the clinic here has just been closed off but every afternoon here there's usually a delivery and down in the [city-centre housing complex] is another place. So, the afternoons aren't the best of places to be going around here really you know. People are used to it you know they just know they are coming. They've threatened...the Guards have been quite active for other reasons like there has been a lot of shootings and that here and the people would say that a lot of that is related to crack cocaine as well; definitely the criminal activity has increased.

north-inner city, drug-treatment service (October 2007)

6.5 Common cause model

Irish research has consistently revealed that underlying social factors – such as educational disadvantage, poverty and inequality – contribute both to problematic drug use and to criminal behaviour.

With regard to the drugs-crime link, studies of drug users have found them typically to be single, aged between 14 and 30, male and urban based; many are still living in the parental home and come from large and often broken families; they have left school before the legal minimum age of 16 and have experienced high levels of unemployment, with their best-ever job being in the lowest socio-economic class; they have a high number of criminal convictions and high rates of recidivism, with a history of family members being in prison; their profile is one of extreme social disadvantage characterised by being from areas with a high proportion of local authority housing and

often with a prevalence of opiate drug use and high levels of long-term unemployment (Furey and Browne 2004; Reynolds *et al.* 2008; Dillon 2001; Hannon *et al.* 2000; O'Mahony 1997; Keogh 1997).

As discussed in the previous chapter, the available evidence from this study's findings suggests that the typical crack user is opiate or methadone dependent with a problematic history of drug misuse, and is likely to share many of the characteristics outlined above.

6.6 Key findings

- Shoplifting, burglary and robbery were reported as common means for users to sustain their crack cocaine habit.
- Service providers reported that increasing numbers of women, including some who had sustained a heroin habit without resorting to sex work as a source of income, were returning to or becoming involved in sex work in order to fund their crack use. One service had experience with women involved in sex work who were based in apartments; the majority of these women's earnings were paid in crack rather than cash. There were no reports of new street-based sex markets developing.
- Eleven participants, including both treatment staff and users, referred to a rise in the number of aggressive and violent incidents in their localities involving assaults related to drug debt, gangland violence and fatal shootings. However, it is not clear whether such incidents are related to crack cocaine or to other substances such as powder cocaine or heroin.
- The extent of involvement of young people in crack dealing is unknown. Of the study participants, crack users claimed that there were numerous young people involved in using and selling crack, whereas service providers said that they had no evidence of young people selling crack.

7 Social consequences of crack use for the user, the family and the community

7.0 Overview

This section considers international evidence relating to the social consequences of problematic crack use. Findings from the NDTRS and in-depth interviews with crack users and service providers on the relationship between crack use and social consequences are examined. Debt, family break-up, homelessness, loss of economic opportunity and neglect are interlinked themes in this section.

7.1 Introduction: social consequences of crack use

Like all problematic drug use, crack can cause serious disruption in people's lives. Crack use is compulsive and, for some people, the pleasurable effects of crack 'precipitate and sustain use to a greater extent than is the case with heroin' (Home Office 2003: 7). As Section 6 of this report underlined, an addiction can be associated with violence, crime and prostitution. And, as is the case with all problematic drug use, crack use can have serious additional social implications for users, their families and the wider community.

At a personal level, relationships with spouses or partners may suffer and it may become problematic for users to sustain any level of formal employment (Sterk 1999; Reinerman *et al.* 1997). The link between homelessness or transient housing and crack use has been documented in international research (Wincup *et al.* 2003). At a community level, the use and distribution of crack cocaine can pose problems for residents and local businesses (Connolly 2006a). International evidence suggests that areas which host open crack markets are adversely affected in terms of economic development (Home Office 2003; San Diego Police Department 1998). Other unsavoury consequences of local open crack markets include discarded drug paraphernalia such as pipes and needles, and sex workers soliciting in public (Home Office 2003; San Diego Police Department 1998). Street-level drug markets, in particular, may exacerbate crime and anti-social behaviour, which can contribute to significant community disintegration and heightened security fears (Connolly 2006b; INCB 2004; EORG 2003; Lupton *et al.* 2002; White and Gorman 2000).

7.2 Homelessness

In Ireland, just under 21% of drug users commencing treatment in 2006 were in employment and 5% were homeless (Reynolds *et al.* 2008). As outlined in Section 2 above, Lawless and Corr (2005) reported that 19% of homeless people had used crack cocaine at some point in their life and 3% were using crack cocaine in the month prior to the survey.

The data provided by the NDTRS in Section 4.6 show that a large proportion of new crack cocaine cases live in unstable accommodation, such as prisons, halfway houses, homeless hostels, or bed and breakfasts. In addition, of the 24 treatment and social services that had recent experience with crack users, 16 had dealt with homeless individuals who used crack. A drug-treatment service specifically targeting the homeless in the north-inner city estimated that just under one-third of its clients were using crack (15 users approximately). In many cases of homelessness, the financial demands of sustaining a crack habit could eventually lead to a crack user's expulsion from the family home due to stealing.

They're put out of the home due to stealing ... behaviours that they've left behind for a long, long time are resurfacing. Resurfacing very quickly.

Clondalkin, drug-treatment service (October 2007)

But he started off doing, smoking hash and poppers kind of thing, then he started smoking gear, doing coke, and he's ended up on crack you see, so... and he ended up homeless basically. He'd a bay up there and stuff, he owns the bay, but his family are still there, his parents and stuff, and he's basically with his wife sleeping in a lift because they were smoking crack and selling everything under them, and... robbing their family and stuff... But that's only one case I know of, there's many more like.

Ballymun, outreach worker (December 2007)

Eviction from private rented accommodation for not paying rent was another reported path to homelessness:

A lot of them would end up homeless. You know because like a lot of our client group would be in private rented accommodation if they are not living at home with their parents. If they are living at home with their parents, their parents are just getting to the stage where they just can't take anymore ... when they're using heroin they would have maybe stole the odd amount of stuff from their family but with crack and cocaine it was just a constant thing. You know there was things missing constantly. The amount of aggression that was going on in the house. The family would just eventually have to ask them to leave. They become homeless. The people who would be in rented accommodation, they just wouldn't pay their rent. You know there is only so much a private landlord will [take] – like with Dublin City Council [DCC] they work with you. You know if you are in rental you have to pay it off or whatever. You know they [DCC] are kind of obliged to do that. Whereas a private landlord isn't.

Dublin 12, drug-treatment service (October 2007)

7.3 Employment

The typical user known to treatment services is a heroin-dependent polydrug user. The lifestyles of such users appear to be too chaotic to sustain a legitimate source of income; as a result, only 6% of new crack cocaine cases were in paid employment (Table 7.1).

Table 7.1 Employment status of new cases of crack cocaine use, 2004 to 2006

Employment status	Number	%
In paid employment	2	5.7
Unemployed	20	57.1
FÁS scheme or other training course	1	2.9
Retired/unable to work/disability	10	28.6
Not known	2	5.6
Total	35	100.0

Among the study's sample of current or former users, the majority were in receipt of social welfare and/or committing theft and shoplifting, drug dealing and prostitution to fund their habit.

Money difficulties, relationships with people, kids, you don't have your kids because your house is gone to bits, your bills will go to bits, if you won't pay them you lose your house. If you have a job, you're lucky to keep your job, because you can't be responsible to do anything you know. You just want the drug and people going in and out of jobs, you know. They would sell anything and that is the truth.

north-inner city, drug-treatment service (September 2007)

Evidence from the in-depth interviews suggests that crack users who were in paid employment used crack in a limited, more controlled manner – spending only their wages and benefits to fund their crack use, or using crack in a binge fashion at the weekend or on their days off. One service provider reported that most employed crack users attending treatment services were self-employed:

What I get paid from here, and my social welfare payments as well. I don't rob, that's all finished with. I wouldn't go to prison for the sake of drugs again. That's just not an option. I had no contact with my daughter for 10 years. And I'm after getting all that back and I kind of wanted to stop the circle if you know what I mean with her.

north-east Dublin, current crack user (October 2007)

But you know it would be about kind of – people would binge it would be like a mini-holiday nearly. Or they would go out and sit in a house where they could get it or buy it and wash it up and would have a certain amount of money and would blow it and then that's it they have to go back to work again. So, most of the people that are doing that kind of work for themselves you know they're self-employed or would have people working for them and they would get away with kind of being able to take a couple of days off without being noticed ... about 20% would have their own businesses. So, they're like painters and decorators, contractors, gardening, stuff like that.

Finglas, drug-treatment service (October 2007)

Individuals in recovery from heroin addiction, who may be receiving training to provide them with skills to re-enter the job market, risk expulsion if their crack use is detected or if use is prompting disruptive behaviour during training.

She would have exhibited quite a lot of aggression and you know the usual problems that are associated with crack, so she would have really stood out on the project a year and a half ago. And for that reason and a lot of other reasons, we had to part company with her, because her use was just too out of control. We aren't a service that could manage somebody in a full crack relapse.

north-inner city, education and training programme (November 2007)

7.4 Implications for the family

Addiction to crack cocaine will impact not only on the user but on the user's relationships and responsibilities:

It's replaced every relationship that they have and every kind of meaningful thing that they've ever had and all they are left with is rocks of crack.

Finglas, drug-treatment service (October 2007)

Three of the female users and one male user interviewed described the effect that their current or former crack habit and associated criminal activities had on their family, particularly their children. One user who dealt cocaine and heroin to fund his crack use upset his family life regularly because of his involvement with drugs and the attention it inevitably received from law-enforcement authorities:

There was tough love where I would have been thrown out of the house, you know and I've come to... I'd be on my knees and they'd take me back in, you know. And I would have been in a relationship, had children, but like everything else, you know, the drugs came first. My partner left me then and my children for a normal life where I would have brought them through chaos, house getting raided, partner getting stopped in her car and getting searched by the armed detectives, you know, with my children in the car, kind of, not to teach me a lesson, you know, but to [say] – we're watching you. That's what it seemed like to me, you know.

Former user, unspecified location (October 2007)

Three female users described how they had neglected their children and wasted financial resources in pursuit of crack cocaine.

I destroyed my relationship because all I was interested in was the drugs, drugs, drugs and it was just as well that at the time when it kind of really started happening my child was the first grandchild and my ma was after taking him back over for a while during the summer. This kind of happened through the three months, the summer period. And I just went drastically downhill... My mother and father and sisters were behind me because none of them are on anything and like, I lived with my mother and they were always there, only for that, like, my kids and all, they would have been gone on me.

north-east Dublin, former crack user (September 2007)

Like I was crying. A bit down today. And I probably bumped into a few in town and then 'Are you getting a rock?' and I would say 'I haven't got the money' where if I have, say, only €20 and we'd pool in and he'd fucking throw an extra one and then you are happy as Larry but then you have problems to face again. You know what I mean. It doesn't be really worth it. And then I would probably be shaking my teeth later on saying 'fuck that'. I could have got a few packets of crisps and popcorn or whatever and watched a film with the kids before I went to bed. You know things like this.

north-inner city, current crack user (October 2007)

Another user described how she had sold her children's possessions to sustain her crack habit and she suspected that her son had developed a crack habit as well:

But, oh Jesus I gave away things out of my home for it, I gave the kids' stuff away. Just, it takes your whole, what would you call it, self-respect, dignity, everything, it strips you naked. You'd end up on the fucking game, God forgive me. There is enough out there doing it for it and all. But I've a young fella that I know is strung out, I'm after being with the Corporation and all, I'm stressed out to bits. I know he's strung out on crack, found a crack pipe. He smokes hash, right, and a hash pipe and a crack pipe is totally different. Must have thought I was a fucking eejit, God forgive me. So, I'm after getting a barring order and all. It's like when I dropped it he picked it up. I'd only, like, dropped it, when I put the habit down and he picked it up. If you can understand me. It's killing me, I have got a protection order and all against him.

north-east Dublin, current crack user (October 2007)

Given the high cost of crack, users could acquire debts very quickly which, if left unpaid, could lead to intimidation from crack dealers. This intimidation can be directed not only at the users themselves but also at their parents or other family members. However, it must be noted that most debt-related violence reported by service providers was in relation to powder cocaine users.

So, debt is another significant issue, and it's the kind of from what I've seen the debt is never cleared you know. Again typical of what we're seeing is 6 or 700 pounds' worth. You know that's paid back and it's run straight back up again. And it's kind of like a loop system, you know. We've had parents that maybe would bail their kids out once or twice, and then they're actually coming up and saying the same thing. Six hundred quid, they need it or the house is going to be shattered. And I think a couple of parents are just, they've put the kids out.

Clondalkin, drug-treatment service (September 2007)

7.5 Crack in the community

As Section 3 indicates, at present, the primary market for crack in Dublin is located in a shopping district in the north-inner city. A number of dealers were reportedly based in this area; a proportion of these would deal openly to buyers.

Ah yeah. Like, I was down on M... Street in May this year and I must have been asked three or four times was I looking for crack, was I looking for rocks. Whereas before you had to know where you were going, you had to know who to ask but they were openly asking were you looking for rocks.

Former crack user, unspecified location (October 2007)

I started going into town, up around M... Street like you'd be walking up M... Street and two or three black fellas would stop you before you got from one end to another 'Are you looking for white?'

north-east Dublin, drug-treatment service (September 2007)

The impact of this street market on the commercial activities of the area was not investigated by this study. Outside of this commercial area, only a small number of crack-dealing sites were referred to, perhaps because many transactions may be organised using mobile phones. However, one treatment service reported that their locality was attracting people from outside the area who were looking to purchase crack. The areas in which this activity was occurring were described as intimidating, but were already established as local markets for other drugs.

It's actually quite intimidating, if you went up there about 9 o'clock, 10 o'clock at night now, you're talking about ... you might see anything from 3 people to 60 people all standing basically together, on the two blocks on the steps, and ... put it this way if you're going up there, you either live there, unfortunately, or else you're going up there for one reason or another. You know. Yeah I don't think it's [crack] as widely spread as people think it is you know. There's basically two spots, [deleted place name] and then [deleted place name], and they're the only places that really are ... obviously there are other spots that I'd know of around here that are selling different types of drugs but generally the two spots are just about crack you know.

Ballymun, drug-treatment service (December 2007)

In addition, two drug-treatment services pointed to methadone clinics as sites where crack was distributed in addition to other drugs. In one north-inner city area, dealers and buyers congregated on a daily basis despite the attention of law-enforcement authorities. Criminal activity, and shootings in particular, had increased in the area.

There are dealers here but a lot of people come from outside ... every afternoon here there's usually a delivery [of illicit drugs] and down in ... is another place. So, the afternoons aren't the best of places to be going around here really you know, people are used to it you know they just know they are coming. They've threatened... the Guards have been quite active, for other reasons like there has been a lot of shootings and that here and the people would say that a lot of that is related to crack cocaine as well; definitely the criminal activity has increased.

north-inner city, drug-treatment service (October 2007)

However, on the whole, few drug-treatment services reported that members of their local communities were concerned about crack cocaine use in the area. There were no reports of crack-specific discarded drug paraphernalia (i.e. pipes) littering local public spaces. Drug-treatment services did report an increase in the numbers of women returning to or entering prostitution (see Section 6.3) but there were no reports of new street-based sex markets developing. Sex workers using crack cocaine operated in established markets or were based 'off street' in apartments.

There would be an awareness around it. But community people themselves? No. There would be around cocaine but yet a lot of them would still just think cocaine would be kind of more recreational. It is the pub goers and all the community. And we have tried to raise awareness you know like I have done a lot of outreach to the pubs.

Dublin 12, drug-treatment service (October 2007)

So, there's not that much of an awareness. There would be in the drug-using community but not really among the families and with the coke users it's a mad one but like... But no there's not really that much awareness of crack in the community. There would be more so in the inner city but I think that would be more due to the likes of Merchants Quay publicising it and stuff like that so.

Finglas, drug-treatment service (October 2007)

7.6 Key findings

- A significant proportion of crack users in treatment are homeless or live in unstable accommodation such as prisons, halfway houses, homeless hostels, or bed and breakfasts. Crack users reported having become homeless because of non-payment of rent, theft, or violence and anti-social behaviour inflicted on family members.
- The lifestyles of such users appear to be too chaotic to sustain a legitimate source of income. Only 6% of new crack cases entering treatment were employed.
- Crack users who were in employment reported that they funded their use from their wages, and used crack only on days when they were not at work.
- Crack use may prevent entry into employment schemes. Individuals in recovery from heroin addiction who are receiving training to provide them with skills to re-enter the job market risk expulsion if their crack use is detected or if use is prompting disruptive behaviour during training.
- Compulsive crack users reported neglecting their children, often diverting their financial resources towards buying crack.
- Given the high cost of crack, users often acquired debts very quickly which, when left unpaid, led to intimidation from crack dealers. This intimidation was often directed not only at the users themselves but also at their parents or other family members.
- Few drug-treatment services reported that members of their local communities were concerned about crack cocaine use in the area. There were no reports of crack-specific discarded drug paraphernalia, such as pipes, littering local public spaces.

8 Health consequences of crack use

8.0 Overview

This section considers findings from international research with regard to the health complications associated with crack use. Data from previous studies and in-depth interviews and focus groups with service providers are then examined to describe the main physical and psychological health consequences associated with crack use in the Dublin region.

8.1 Introduction: health consequences of crack use

Long-term use of crack is associated with a range of physical and mental health problems (GLADA 2004a). The physical effects of crack use on people include narrowed blood vessels, dilated pupils, increased temperature, faster heart rate, and high blood pressure. These medical symptoms can lead to chest pain, disturbances in heart rhythm, lack of oxygen to the heart muscle, respiratory failure, strokes, seizures and headaches (NIDA 2004). Because crack has a tendency to decrease appetite, many chronic users can become malnourished. Further potential risks include ammonia poisoning from protracted use of poorly manufactured crack and the use of acetone (used to reclaim cocaine from crack pipes) may cause kidney, liver and nerve damage (NACD 2007b).

In terms of maternal crack use, it is important to dispel erroneous myths such as that of the incidence of 'crack babies' portrayed in the US media in the 1980s (NIDA 2004). The specific effect(s) of crack on the foetus remains unknown. However, the effects of maternal crack cocaine use may include premature birth, low birth weight and smaller head circumference (NIDA 2004), although these symptoms may be caused by other concomitant factors such as alcohol use, tobacco use and/or poor diet.

As is the case with users of other illicit drugs, crack users may be at risk of contracting HIV, hepatitis B and hepatitis C through sharing injecting equipment, sharing crack pipes, and engaging in risky sexual behaviour. Research has underlined that drug use, including crack use, can 'interfere with judgement about risk-taking behaviour, and can potentially lead to reduced precautions regarding sexual behaviours, the sharing of needles and injection paraphernalia, and the trading of sex for drugs, by both men and women' (NIDA 2004: 6). Recent research in Canada has demonstrated the link between crack smokers who share makeshift glass or aluminium pipes, which may cut their lips, and thereby facilitate the transmission of hepatitis C (CARBC 2007).

There are considerable long-term psychological consequences of crack use. Crack use may result in increased anxiety, agitation, insomnia, depression, psychotic illness and eating disorders. Use of psycho-stimulants such as crack cocaine may also be linked to suicide (NIDA 2004; Warner 1993). Insomnia may emerge as problem, and may result in users turning to sedatives such as alcohol, benzodiazepines and opiates to recover their sleeping patterns or to relax after using crack.

8.2 Physical consequences of crack use

In Ireland, there are no routine data sources that collect information on the physical consequences of crack cocaine use. As a result, data in this area are limited to once-off studies. In March 2004 CityWide published the results of a survey on the extent to which 27 community-based drug projects were dealing with the problems of cocaine use (CityWide 2004). The follow-up survey reports a deterioration in the general health of clients with problematic cocaine use, with 39% of the projects surveyed reporting a rise in the number of clients experiencing abscesses and wounds due to poor injecting habits. Projects also reported increases in weight loss; sexually transmitted infections (STIs); heart conditions; amputations; incidences of opiate users who had been previously stabilised on methadone now destabilising through cocaine use; and risk-taking behaviours among clients using cocaine. The health consequences of crack use are relatively similar to those associated with the use of powder cocaine (NIDA 2004). However, the different means of taking cocaine can also produce different diverse effects. Regularly snorting powder cocaine can lead to complications – such as loss of smell and nose bleeds – while smoking crack cocaine may cause breathing complications.

The majority of known users in Dublin are most likely to be polydrug users, particularly former heroin and/or methadone users. Reports from users and services suggest that many have already suffered considerable ill effects from injecting opiates such as contracting HIV or hepatitis C, soft-tissue infections, blood-clotting problems, or having had an amputation. In general, the main crack-specific ill effects reported were rapid weight loss (13 reports) and heart/breathing problems (9 reports). The findings of the CityWide (2004) study support the experiences reported by participants in the in-depth interviews.

Nonetheless, a small number of participants reported more severe complications. One drug-treatment worker and one user reported instances of crack-related deaths (a heart attack and fatal seizure):

Like the majority of deaths that we would have within the organisation – like I think we have had two in the last week. One of them wasn't a client of ours. She was a girlfriend of a client, died last Thursday, and we had a young man died two weeks ago on the Friday. Both were crack-related. The young girl that died, I think she was 36. She had a massive heart attack. We still don't know how the young man died.

Location anonymised, drug-treatment services (October 2007)

Another female user reported that one of her son's friends had suffered a fatal seizure or fit while smoking crack cocaine. His death did not deter her son from using crack:

It's killing so, my youngest, the one I'm talking about, his friend died four or five weeks ago. Doing it on the pipe and he didn't know he took fits. Took a fit, took a few fits that night I am told, they were all with him. They all done it again the next night. Like, they don't get afraid. The next night on the Friday, he's dead about five weeks, he was a lovely little young fella as well, but I don't know whatever was mixed with it was like splinters of glass or something, because you can mix anything white, do you know? When he took the pipe, after about 10 or 15 minutes, I'd say he went through, probably, another pipe. The blood started coming out of his nose, ears, mouth – dead. Yeah, it didn't stop them again. Do you know the way?

north-east Dublin, current user (October 2007)

Another former user had suffered multiple organ failure after years of powder cocaine/crack use:

Yeah. I was using drugs right up until April/May of last year and my kidneys failed, cocaine abuse, ended up very sick in hospital. Organ failure, heart under pressure, liver, I'd be hepatitis C positive. So it was, I was dead, not that I was dead, my kidneys had failed, my legs had swollen, my body wasn't processing fluid and I was just getting sicker and sicker until I collapsed. I ended up on a life-support machine in Navan Hospital and it was my last chance to do anything about my drug problem.

Former crack user, unspecified location (October 2007)

One former user believed she had miscarried because of respiratory problems linked to crack use:

The crack was affecting my lungs. I have asthma anyway. So I hadn't enough oxygen for myself, so there was no oxygen for the baby, so the baby's lungs weren't developing...he only lasted three days and I know for a fact that was through crack cocaine so it was.

north-east Dublin, former crack user (September 2007)

8.3 Psychological consequences of crack use

As with assessing the physical consequence of crack use, there are no routine data sources that collect information on the mental health consequences of crack cocaine use. Therefore, data in this area are limited to once-off studies. As mentioned above, in March 2004 CityWide published the results of its survey on the extent to which 27 community-based drug projects were dealing with the problems of cocaine use (CityWide 2004). Twenty-two per cent of projects reported an increase in mental health problems, including depression, anxiety, stress, psychotic episodes and attempted suicide; this supports the findings of the in-depth interviews.

Drug-treatment and social services with experience of crack users did not perceive a large difference between the induced effects of powder cocaine compared with crack cocaine-induced effects. Seventeen services reported psychological ill effects from crack cocaine, including increased aggressive behaviour towards family members, friends and strangers and service providers:

Also anxiety, like from anxiety, increased paranoia, increased atmosphere in the centre if these clients who have used crack start coming in. Now the same with coke actually. We're not really going to decipher between the two because we're seeing the same symptoms from both from injecting cocaine as smoking crack. The increased paranoia, the increased anxiety. Just a bad tension within the centre and within the drop-in.

Clondalkin, drug-treatment service (October 2007)

Mental health problems mostly, you know that would be the main thing ... paranoia, aggression you know just the normal run-of-the-mill stuff, except it would be a bit different, it would be more pronounced in people that are using crack especially after bingeing.

Finglas, drug-treatment service (October 2007)

Eleven drug-treatment services referred to symptoms of paranoia exhibited by clients after heavy use of crack cocaine:

We would have seen a lot of psychological effects on people's mental health. You know that has just really deteriorated. You know there is one guy would come in here totally paranoid, you know he will kind of look around the room and say 'You know are those sockets bugged? Because I am sure last week when I was in here I could hear people talking.' You know stuff like that. Another guy would come in and he would cry a lot. He was a total wreck. You know and he would say 'I know they are all talking about me out there I know they know I am in here'.

Crumlin, drug-treatment services (October 2007)

Three current or former crack users described symptoms of depression, which had led to contemplation of suicide. All had used crack on a daily basis:

When I was on crack cocaine, I despised me. I think that's what made me self-harm and try and commit suicide because the crack was sending me off my head, inside my head like mentally, it's just mentally. Whereas the heroin was physical, the crack cocaine is just pure mental. It's in your head and it's just, it's like, when I was coming off it, it was like all little spiders in my brain or something.

north-east Dublin, former crack user (October 2007)

In one case, a female user referred to her battle with depression and the vicious circle of using crack to recover from episodes of depression. She had already lost her partner and the father of her children to an overdose:

Like a few days I have really been feeling down and there will be nobody there for you ... I hope today hurries and is over and I will go to bed and wake up the next day and say 'Jesus thank God I'm still here'. Like I didn't do anything today you know ... I am at my suicidal point now... As I said, I could walk out and get rock and feel grand. And then I am at home and crying and the kids are asking 'Mam, what's wrong? Why are you down? Daddy is looking down over us.' They think it is because Daddy is gone. And I don't know what to be telling them anymore you know.

north-inner city, current crack user (October 2007)

8.4 Key findings

- According to available data, the most common physical side effects of crack use were breathing problems, heart problems and rapid weight loss. Among the more serious consequences reported was fatal heart attack.
- The available data indicate that psychological consequences of crack use included paranoia, aggressiveness and depression. A small number of users reported contemplating self-harm as a result of their depression.

Part 4

Responding to crack cocaine: towards a crack cocaine strategy

9 Treating crack use

9.0 Overview

In this section current treatment responses to crack cocaine misuse in Dublin are reviewed. Difficulties attracting users into treatment and retaining such users in treatment are considered. The views of treatment practitioners with regard to improving treatment services are then presented.

9.1 Introduction

Internationally, the most successful approaches to reducing or ceasing cocaine use (including crack) are the psychosocial interventions, such as cognitive behavioural therapy; however, these interventions can only be successful if the user is attracted to and retained in treatment. In order to attract people into treatment, the service provider must be able to deal with the immediate needs of the user (such as acute medical problems or accommodation); in the medium term they must be able to provide services to increase the user's well-being (such as complementary therapies and personal-development opportunities). In Appendix A, Long and Keenan (2007) present the effectiveness of various types of psychosocial and medical treatment for problem cocaine use.

9.2 Current treatment responses to crack misuse in Dublin

Findings from in-depth interviews and focus groups, in addition to information received from the Health Service Executive (HSE), indicate that many current treatment responses to crack addiction evolved from responses to the increase in problematic powder cocaine use.²⁰

Eight services reported receiving crack-specific training and information either from experienced practitioners from the UK, or during the course of workshops which they had attended in Merchants Quay Ireland. Just 5 of the 31 drug-treatment and social services consulted reported a lack of knowledge about treating clients for crack cocaine use. The most common responses reported included alternative or complementary therapies such as acupuncture and massage (16 services), one-to-one counselling (8 services) and cognitive behavioural therapy (5 services).

²⁰ Not all drug-treatment services consulted could provide specific therapies. A portion acted as drop-in centres and linked clients into therapeutic services in accordance with their needs.

Many services offer a combination of these therapies, or acted as a link to providers of such services (such as counselling). Overall, drug-treatment services were enthusiastic about the benefits of an approach which encompasses both counselling and complementary therapies. Acupuncture was thought to be very useful in calming clients who presented in an agitated or chaotic state and it offered an attractive incentive for users to attend services regularly:

It's not realistic to expect them to sit in the room with you for an hour, and that. So, we would have sort of a holistic side in a sense. We have three of our staff trained up in acupuncture, so we'd use acupuncture which helps in another way. Because again what I found is that clients don't want to get into massive one-to-ones. They just want to find a way like to chill out and come back down, to take some kind of edge off their comedown. And the acupuncture is a great tool to be able to use because you can get it kind of in the door and maybe for 5 or 10 minutes you get to have some kind of intervention...

Clondalkin, drug-treatment service (October 2007)

Acupuncture doesn't cure anything. But for some people it works very, very well. It doesn't do anything for other people. You know? And what I would be suggesting is that if you have good holistic people that can talk the talk, you know the word that they use is ... placebo, placebo effect you know in other words if they feel it's going to do something for them, then it will. It also gives people a feeling that there's something for them when they're going there. They get something out of it, they feel good about it.

Tallaght, drug-treatment services (October 2007)

Four services reported providing starter or welcome packs to users, which include contact information for different services, relaxation materials such as lavender oil, a relaxation CD and other products. The philosophy underpinning the welcome pack is to provide users with support tools even if they do not present to services on a regular basis:

So, people are finding bits in this pack you know that'll work for them, so we find this is a really useful tool ... because if somebody comes in you might not see them again. They might be really paranoid, they might go out thinking I'm a head banger. They might think they don't like the place, or people saw them coming in you know what I mean, but they go away with this thing that it looks like they're going to college, you know what I mean, so they go away with it and they can kind of, later on they might pick up the card or play the CD...that's how it works.

Ballyfermot, drug-treatment service (October 2007)

Some services were in a position to provide complementary therapy such as acupuncture, reiki, art therapy or massage on a daily basis. Essentially, these therapies offer clients alternatives to using drugs, which may aid their efforts to break up their pattern of drug use. A number of these services had trained existing staff members to provide therapies; this enabled them to offer clients an immediate response, rather than giving them another appointment for a later date, which they might not attend. However, not all services have the staff or resources to provide such interventions.

In 2005, the Department of Community, Rural and Gaeltacht Affairs funded and evaluated training courses for 53 frontline staff and 76 key workers (Crampton 2005). The courses were organised through Merchants Quay Ireland. In 2006 and 2007, the HSE in conjunction with the University of Leeds trained 38 counsellors in the statutory and voluntary/community sector in the use of cognitive behaviour coping skills (CBCS). This training programme is recognised widely by clinicians and professionals in the addiction field as the most appropriate method available to enhance the skill sets required by staff working with stimulant misuse issues. Further courses are due to be held in 2008 (Joe Doyle, HSE, personal communication, June 2008).

The Department of Community, Rural and Gaeltacht Affairs also funded and evaluated a number of projects that address cocaine use. A community-based project involving St Dominic's Community Response Project and Killinarden's Community Addiction Response Programme in Tallaght was (according to the evaluators) effective and very good value for money (Goodbody Economic Consultants 2006). The project caters for problematic intranasal cocaine users mainly, but also treats a small number of crack users. Interventions used at the project include the advertising of service availability; the holding of project meetings; a proactive outreach programme; the maintenance of a helpline; the promotion of relationship building between service suppliers and clients; the use of individual care plans; the provision of individual counselling; and the use of complimentary therapies. This example of good practice could be applied elsewhere.

9.3 Attracting crack users into treatment

Sixteen services reported that the biggest challenge is attracting crack users into treatment and retaining them long enough to achieve long-lasting change. Reported reasons for users' reluctance to seek treatment include:

- 1 Users' scepticism of the benefits of treatment, given that there is no medical substitute.
- 2 Users' fear of suffering penalties from their methadone or employment programmes.
- 3 Users' lifestyles being too chaotic to facilitate them attending treatment regularly.
- 4 Users' perception that crack use is stigmatised, thus discouraging disclosure.

Six services reported that crack-using clients on heroin-recovery programmes may be reluctant to seek specific treatment for their crack addiction. Users may believe that they risk suffering punitive measures from methadone clinics should they disclose their crack use or should it be detected in urine analysis. Such penalties could ultimately lead to a loss of privileges regarding their methadone maintenance, for example the loss of 'takeaways' – a supply of methadone for a number of days at a time (losing 'takeaways' means that a client has to attend a clinic every day for his/her daily dose of methadone). Such a routine restricts a client's working or recreational options. As a consequence, some users will not disclose their current drug-use patterns to service providers, and will either avoid using crack when they are due to give a sample of urine or submit a 'bogey' (another person's urine which is clear of all illicit substances):

Some try to hide it because the way of dealing with people with heroin nowadays is that if you have a dirty urine you're penalised. Penalty usually is that you're put on dailies. Which means you can't go on holidays, you can but it's very, very difficult. You can't get a job because you've to go to the chemist every day. Unless you happen to have a time that's very, very suitable. So, there are lots of difficulties there for people. So, the whole climate of not saying what you're on is there. So, that makes it difficult alright? So, we would have a number of people that are using crack yes.

Tallaght, drug-treatment service (October 2007)

Similarly, users on education or training programmes, which require a stable lifestyle, may fear that disclosing crack use will lead to their expulsion from these programmes:

I'd say it's a lot of fear about how people are going to approach them or maybe they'll lose their course, or their job. So, you know it's community employment and it's you know basic training programmes, but it means a lot to them, and to lose that to them would be a great fear and they probably wouldn't ... that's why we're saying that ... well then a lot talk about it, and when I ask people you know what are you seeing in the area? They'll tell me what they're seeing and who's taking it but not ... but that they're not.

Ballyfermot, drug-treatment service (November 2007)

They're probably not saying they're using it, yeah, see it's difficult down here for us, like, a lot of the people who come in here would be on a community employment programme and you have to be fairly stable, like they're not going to come in here and say, say they're on methadone and they're on 80 mls of methadone, they can't come in then and say the next day – listen I'm after being out all night smoking crack. Because you're not stable, know what I mean? The criteria for our programme is you have to be fairly stable to remain on this, so it's a bit of a catch, you know what I mean?

south inner city, drug-treatment service (September 2007)

Both opiate-dependent and non-opiate-dependent crack users may not believe that existing drug-treatment services, which are geared towards the demands of heroin addiction, can help them, given that there is no pharmacological substitute such as methadone:

I suppose there's not a lot to offer them either you know. Like methadone is a great carrot to draw people into a service, because you know with treatment, but there isn't the equivalent there for cocaine users...

north-inner city, drug-treatment service (August 2007)

Yeah, some are looking at the point of going into treatment. But mainly again that's because what's the reinforcement for them going into treatment? You know that that's the specialist in opiate addiction and the clients know that, you know. So, we know when a client comes in and maybe has an opiate problem and maybe would identify straight away what programme they want to go to, we can give them the information. Again put it back to coke and crack, where is the specialist residential programme there?

Clondalkin, drug-treatment service (October 2007)

9.4 Retaining crack users in treatment

Encouraging clients to attend regular appointments and therapy sessions can be problematic. Users seeking treatment often look for an immediate response, such as a residential programme or counselling, which a service may not be in a position to provide. Seven services reported the difficulties involved when clients seek treatment in a chaotic state, and services may find it hard to assess these clients and communicate with them in a meaningful way. This is especially problematic given the risk that the user may not seek help again for a long period of time:

But those on crack or cocaine usually, it's very fleeting that you'd see them, very ... do you know do you find like they'd be hectic, a lot more hectic they'd be in and out and you might see him for once this week and then in a couple of weeks' time. So, it's very hit and miss as to how often you'd see them, you wouldn't be able to say 'oh that person is going to be in this day', there would be no pattern with them like.

north-inner city, drug-treatment service (September/October 2007)

Since crack has come in, that has kind of shifted. And a lot of crisis coming to the centre, a lot of panic. You know and it's quite hard to manage that from a service point of view ... we try to accommodate, we try to be there when needed. It might take over the whole centre. So, your structured appointments have to kind of take a back seat which you know it's hard getting that balancing act ... you need to be able to get to see them then and there. If you don't, you lose them.

Clondalkin, drug-treatment service (October 2007)

9.5 Improving or providing treatment services: practitioners' perspectives

Nine drug-treatment services reported the need for 'stimulant' or cocaine-specific services that is separate from opiate-addiction clinics. It was reported that, owing to stigmas associated with heroin use, non-opiate users would be discouraged by the association of cocaine services with those for heroin addiction. Although, in terms of user profile, there is a considerable difference between powder cocaine users and crack cocaine/intravenous cocaine users, drug-treatment service personnel did not perceive huge differences in treatment strategies for cocaine addiction and crack cocaine addiction:

I really believe that you know the addiction services have to engage with the idea of stimulant clinics and working with people in a very holistic way in terms of either black box treatment, cognitive behavioural therapy...and I think it has to be very separate from methadone clinics. I think they're two completely different drugs. I think they have two completely different actions on the body and I think particularly from the point of view of crack, I think people have to be picked up very, very quickly. Because if they're not picked up quickly you know their health suffers. I think you know health is a huge one. And you know their health can very quickly get out of control. And I think if there were stimulant clinics and all, it would probably take three or four dotted around the city for people to actually attend, and to work with people who are well used to working with crack users, as opposed to heroin users. And I think we have to very quickly get out of the mindset that we can treat crack users within the same framework as a methadone clinic, because I just don't think that's realistic.

north-inner city, training and education programme (November 2007)

However, there were several opposing arguments for creating a 'stimulant service':

- Three services supported the concept of a crack-specific service. Their logic was that, unless services are pinpointed, users will not believe that services can help them.
- One service pointed out that the majority of powder cocaine users and the majority of crack cocaine users exhibit contrasting social profiles, and that mixing users with such different profiles would only discourage attendance.

In addition to the provision of stimulant-specific services, a number of key areas for improvement were identified by drug-treatment services. These included:

- resources to provide an immediate response or perform a crisis intervention (nine services);
- residential treatment options to address factors that may trigger crack use, particularly for polydrug users (ten services);

- more outreach work to identify crack users and encourage them into treatment (seven services);
- additional crack-specific training to augment existing core skills (six services);
- quicker access to psychiatric services in the case of high-risk patients (three services);
- the promotion of harm reduction, such as safe crack pipes (three services).

9.6 Treating polydrug use

As Section 5 indicated, the majority of treatment services' clients who present reporting crack use are polydrug users with a history of opiate dependence in particular. Crack is one of many drugs they may be using along with heroin, methadone, benzodiazepines and alcohol. Two services argued that services should be geared towards polydrug use and treat all drug misuse rather than setting up structures for one particular drug. Five non-medical services referred to the challenge of treating polydrug use, and some expressed concerns about the approach of methadone clinics to crack. In particular, these services felt that service providers were ignoring clients' polydrug use:

One person [crack-using client] is on heroin and crack and a few others would be on methadone...the majority would be [on] methadone, they're in clinics [where] they are getting tested, supposedly getting tested for urines but ... are getting away with giving dirty urines or they are now getting someone else to give urines for them. I don't know, they could be using bogey urines. I don't know how that works. We wouldn't have that many links in that way with clinics and it's probably better for it because if you started kind of linking in with clinics and saying this person is presenting and he's using crack and he's still on the methadone it would probably upset the clinic a bit I would say – so we tend not to go there.

Finglas, drug-treatment service (October 2007)

You know I don't think clinics are helping. And when I say that you know people that are polydrug using and I know one person at this present time who is injecting coke. Her family have rang the doctor. And methadone still hasn't been reduced. You know and they tell you why they are using methadone because they are being treated for heroin dependency. Why leave her on the same dosage if she is going to put cocaine into her?

south inner city, drug-treatment service (September 2007)

Oh God I really, really don't know. You see we haven't really tackled the other issues yet. Even though we're saying we have but we haven't. It's very hard to move on to, and again, no criticism, nothing personal against the staff or I really think the health board need to sit down and revise the satellite clinics. And the clinics in relation to the heroin addiction with the methadone, like, we haven't got that right if you know what I mean. I know there's the benefits, the positives, it cuts the crime rate down and all that but I don't know, I really don't know because, as I said, most of them like what they do.

north-east Dublin, drug-treatment service (October 2007)

9.7 Key findings

- Internationally, the most successful approaches to reducing or ceasing crack use are the psychosocial interventions (such as cognitive behavioural therapy); however, these interventions can only be successful if the user is attracted to and retained in treatment. In order to attract people into a treatment programme, the service provider needs to deal with the immediate needs of the user (such as practical health, social and family issues); in the medium term the provider must be able to deliver services to increase the user's well-being.
- Current treatment responses to crack use, which include complimentary therapies, counselling and cognitive behavioural therapy, evolved from responses to the increase in problematic powder cocaine use. Of the 31 drug-treatment and social services participating in interviews and focus groups for this study, five reported a lack of knowledge about treating clients for crack use.
- The HSE reports that 38 staff members have been trained as cognitive behavioural therapists, and Merchants Quay Ireland has trained 53 frontline staff and 76 key workers in cocaine-related responses.
- Some service providers and crack users argue in favour of separate facilities to address cocaine use. There is a widespread perception that the addiction services in Dublin are methadone-prescribing or -dispensing services only.
- Since most crack users are polydrug users, the establishment of stimulant-specific services requires careful consideration. Ireland may need to consider placing outreach and psychosocial treatment at the centre of its addiction services, with the addition of medical interventions as a specialist support for detoxification (from opiates, alcohol and benzodiazepines), methadone maintenance and psychiatric treatment.
- Some crack cocaine users have lifestyles that are too chaotic to facilitate their attendance at treatment on a regular basis, and treatment services need to be able to make allowances for these people when they are in the initial stages of treatment.
- Some opiate users in treatment did not report their crack use to service providers in case they received sanctions as part of the methadone protocol, or lost access to their children. Other clients who had reported their crack use to service providers, had not been provided with any treatment.
- The Department of Community, Rural and Gaeltacht Affairs has funded a number of cocaine-treatment initiatives.

10 Policing crack markets

10.0 Overview

This section reviews law-enforcement activities in relation to drug supply. The overall objective of such activities is considered. Using data from a focus group with members of the Garda National Drugs Unit, a description of street-based interventions by An Garda Síochána is provided. This includes Operation Plaza which was established in response to the emergence of crack cocaine in Dublin. The role of the gardaí in diverting drug users into treatment and some of the challenges faced by law enforcement in this area are also considered.

10.1 Introduction: responding to drug supply

It is important to consider what policing interventions in illicit drug markets are seeking to achieve and how specific market structures and forms of organisation can impact on interventions. Policing initiatives, be they in terms of street patrols or intelligence-led operations of a more covert nature, strive to disrupt markets and thus reduce or control supply. On the other hand, demand-reduction strategies attempt to target users and divert them into drug treatment, by means of arrest referral schemes, for example. It is assumed that by reducing supply and demand the market will ultimately shrink and drug-related crime will decrease accordingly.

A number of writers in this area have shown, however, that law-enforcement initiatives can have unintended consequences (Wilson and Stevens 2008). This is partly due to a limited evidence base in relation to supply-control activities. As May and Hough (2001: 141) point out: 'The relationships between the supply of illicit drugs, the demand for them and enforcement activities are poorly conceptualised, under-researched and little understood.'

Applying basic market logic, it might be assumed that successful attempts to stifle supply would lead to higher prices, and that this in turn would reduce consumption. In reality, however, most estimates of prices throughout Europe show them to be either stable or falling (EMCDDA 2006). There are a number of possible reasons for this. First, it is estimated that law-enforcement activity leads to the seizure of only 10%–20% of the drugs in circulation; the amount that remains undetected is such that the long-term impact of successful enforcement is likely to be minimal (Connolly 2006a; UNODC 2005). Second, drug distribution systems adapt quickly, so that where drug suppliers have been arrested, they will quickly be replaced (Reuter *et al.* 1990). Third, demand is often inelastic for problematic drug users, relative to moderate or recreational users, and increased prices may simply lead them to engage in greater levels of crime in order to pay the higher prices (Wagstaff and Maynard 1988).

In the UK, there is a strong consensus that police crackdowns or targeted enforcement initiatives that are deployed over a short period of time and focus on specific drug-dealing areas have only limited success. Dealers often return and continue to distribute illicit drugs when police resources are directed elsewhere (Burgess 2003). The mobile phone has greatly increased the capacity of closed markets to operate without detection. In addition to this, crack houses are considered to be a response to the increased policing of open markets. Wilson and Stevens (2008: 9) conclude: 'When viewed in the context of a market, preventing the buying and selling of all illegal drugs is not an achievable goal of law enforcement.' The ability of crack markets to adapt to law-enforcement activities has also been identified in the US. An ethnographic study in New York described how the process of crack distribution has adapted and changed in response to law-enforcement policies and competition (Johnson *et al.* 2000). In the late 1980s and early 1990s crack cocaine was primarily sold in the street and was highly visible. In response to law-enforcement policies, crack selling moved indoors to crack houses or was sold out of what appeared to be legitimate businesses such as laundromats and pool halls. Crack sellers also became more cautious about who they sold to in response to 'buy-bust' techniques used by the police. These operations involve undercover police purchasing drugs and then immediately arresting the seller once the transaction is made. The situation in Ireland is similar to that in the UK, where the advent of mobile phones has made the operation of closed markets easier.

Effective intervention strategies may be those that combine attempts to disrupt local markets, thus rendering them less predictable to both buyers and sellers, with attempts to divert drug offenders into treatment services (EMCDDA 2005). In the UK, arrest referral schemes offer the opportunity for drug-using offenders detained by the police to meet with an arrest referral worker in police custody and to be referred to drug services (Burgess 2003). However, evaluations of this scheme suggest that crack users are the least likely to take advantage of these schemes. Reasons for this include the lack of availability of immediate help, the volatility of users and a lack of faith in what treatment services can offer. Another strategy is to frustrate the operation of drug markets by placing obstacles in the way of the buying process. The regular patrolling of drug hotspots and intensive policing of new 'open drug scenes' can facilitate this. While such an approach is unlikely to deter regular drug users, it may serve to deter casual users.

In recent years we have witnessed throughout Europe a greater level of debate about the most appropriate way to intervene in, and respond to, local drug markets and related problems (Connolly 2006b). Strategic thinking, in-depth problem analysis, long-term planning and partnership between agencies and stakeholders are characteristic of this new development. Such partnership approaches often involve collaboration between law-enforcement, social and health services, and other stakeholders, including

local communities. There is growing evidence that partnership working offers the most sustainable method of responding to street-level drug markets (Mazerolle *et al.* 2006; Appendix B). Such responses typically involve a combination of law enforcement and harm reduction (Connolly 2006b; Scottish Executive 2004).

It has been argued that enforcement's effectiveness at suppressing drug use declines as the size of the market grows (Tragler *et al.* 2001; Kleiman 1993). This highlights the important role of law enforcement when it comes to addressing new emerging drug markets. Caulkins (2007) argues that, unlike prevention programmes, law enforcement can concentrate its efforts on specific locations at particular times and consequently it is uniquely placed to prevent or disrupt emerging drug markets.

10.2 An Garda Síochána: supply control activity

Since 1997, a number of operations have been undertaken by An Garda Síochána to disrupt street level drug supply (GNDU, personal communication, 19 May 2006). Operation Clean Street, which targeted on-street drug dealing, ran from 1997 to 2005. This involved undercover gardaí entering specific drug 'hotspots' and monitoring suspected drug activity. Parallel to Operation Clean Street, Operation Nightcap came into existence; this targeted pubs and clubs, mainly for drugs associated with the nightclub scene such as ecstasy and heroin. Operation Clean Street was regarded as a success from a law-enforcement point of view, leading to over 1,100 individual convictions for supply of heroin (GNDU, personal communication, May 2006). However, the success of Operation Clean Street raised the issue of the so-called 'Water Bed Effect' whereby drug activity was displaced to other locations around the city.

Operation Plaza

Using Operation Clean Street-type tactics, Operation Plaza was initiated in April 2006 in response to reports of crack cocaine dealing in the north-inner city (GNDU, personal communication, May 2006). During this three-month operation, gardaí established a broad picture of the distribution of crack in the Dublin region. It was found that the market was confined to a city-centre shopping district and an area in west Dublin. Gardaí identified approximately 17 individuals dealing in crack. A number of arrests resulted from this operation.

As discussed in Section 3, crack users and drug-treatment providers consulted between September and November 2007 stated that the same city-centre shopping district remains one of the prime locations for purchasing prepared crack cocaine:

Like, I was down on M... Street in May this year and I must have been asked three or four times was I looking for crack, was I looking for rocks. Whereas before you had to know where you were going, you had to know who to ask, but they were openly asking were you looking for rocks.

Former crack user, unspecified location (October 2007)

Participants in this study also referred to the emerging availability of prepared crack cocaine outside the city centre:

There's not a lot of people who know how to wash drugs properly. So these fellas are bringing in good coke, washing it up, they have their business, just say in Ballymun or Santry. They'll get somebody down here, probably a little 19-, 20-year-old to start selling rock for them. He'll start selling and everyone will start buying it. So that's how they get their business brought down to the likes of here.

north-east Dublin, former crack user (October 2007)

So, there is about four people in the community that could be named as dealers for crack cocaine. But, as I said, it's only the last few weeks.

Dublin 12, drug-treatment service (October 2007)

10.3 Supply reduction: the challenges

Information from Operation Plaza suggested that crack cocaine was rarely imported in the form of crack. Dealers were importing powder cocaine and selling to crack users who would prepare crack cocaine themselves. According to the GNDU, non-Irish national dealers have quite a sophisticated importation system (GNDU, personal communication, 19 May 2006). As noted above, unlike Irish dealers who, it is reported, will attempt to import 10 kilos of cocaine at a time, non-Irish national dealers may employ 10 different couriers to carry a kilo each. Findings from this study suggest that prepared crack cocaine is available from dealers based both in the city centre and the suburbs.

At the street level, the use of mobile phones has also become an issue. In 1997, at the beginning of Operation Clean Street, mobile phones were not used to the extent that they are now. Their use has contributed to a less visible form of drug dealing. There are a limited number of places where people can go and buy drugs openly on the street. In this study, crack users reported a number of risk-management strategies employed by dealers; the majority of these strategies were underpinned by the use of mobile phones. In light of greater attention from the gardaí, dealers were reportedly using a variety of strategies to avoid garda detection. These included carrying small amounts of crack to exchanges with users; depositing the drug in a hidden area for users to collect (rather than making an exchange); sending prospective purchasers to different areas of the city instead of making the exchange in the established city-centre market; and refusing to deal to unknown clients.

He'd know me, I'd know him, you know? If I was ringing from a landline, you know I'd say – 'Look, I have money, are you available?' 'Yeah meet me up at...' So, you'd walk up and meet him then. You'd give him the money and if you were on a mobile, more times than not he'd walk out of his flat, come down and meet you at a certain spot and the crack would be there on the ground. He'd after being out before you got up there and it'd be under a can, it'd be beside a bin. That he wasn't carrying it down the street in case he got arrested, he'd give you the money – 'there it's under that, in the bin, it's behind that can, it's under that wheel'.

Former crack user, unspecified location (October 2007)

Then as I said if you're talking about M... Street if you haven't got it there and then probably making a rock because in one of the shops upstairs...out the back room, they make it. You know. And they'd say ring in 20 minutes and they would ring someone else and another coloured guy would go to that coloured guy and bring it down and cross over. And that man is shaking their hand; he is dropping the rock while you're passing the money at the shop doors. It's mad the way it works. Like it's being watched a lot by undercover police.

So that's why they meet you offsite now. So, I don't know if they are still doing it up there but I haven't been up there in a long time because your man Rock One, everybody goes for his stuff. But yeah it's being watched a lot so everybody is wise to that. But if there is no one kind of around they do all go up and down, straddling around, secretly to anybody.

north-inner city, current crack user (October 2007)

10.4 Price and the demand for crack

As discussed above, relative to moderate or recreational users, the demand for drugs is often inelastic for problem drug users. Price increases, where they occur, do not necessarily deter use but may simply lead problematic users to engage in greater levels of crime in order to pay the higher prices. Moreover, it has been noted that drug prices have generally fallen throughout Europe in recent years. In the US, research suggests that demand for crack was created by its relatively cheap price. Unlike powder cocaine, crack was sold in smaller and cheaper amounts, making it financially more accessible to the urban poor (NIDA 2004; Reinarman *et al.* 1997).

Nonetheless, this study found some evidence that the high price of crack does deter use:

No, I haven't knocked it on the head. It's just that I don't do it every day now. But if I had the money I would. Everybody thinks coke is dear but crack is more.

Current user, north-inner city (October 2007)

I knocked it on the head but I have the slip at the weekend. Like, if I had more money I would do it. But I was locked up loads of times in Mountjoy.

Current user, north-east Dublin (September 2007)

Information from Operation Plaza and crack users participating in this study suggested that crack cocaine had been supplied by a small number of dealers based mainly in the city centre. These limited sources of supply may have contributed to a relatively stable high price. The price of crack may be a key factor in relation to any potential escalation in its use.

10.5 Arrest referral: diverting users into treatment

A number of Irish studies have shown the strong correlation between drug-treatment and crime reduction (Connolly 2006a; Cox *et al.* 2006). The establishment of arrest referral schemes is viewed as an important means of diverting drug users into treatment at their first point of contact with the criminal justice system – the Garda station. Action 13 of the National Drugs Strategy 2001–2008 obliges An Garda Síochána ‘To monitor the efficacy of the existing arrest referral schemes and expand them, as appropriate’. A report on a pilot arrest referral scheme in Dublin’s north-inner city raised a number of questions about the efficacy of the model being applied (North East Inner City Drugs Task Force 2005).

The north-inner city pilot scheme involves cooperation between the outreach services of the Health Service Executive Northern Area, An Garda Síochána North Central Division and the local drugs task force. Participation in the scheme is completely voluntary for arrestees and does not interfere with the normal processing of the criminal justice system. The initial take-up of the scheme was low. The report provides data for juveniles arrested in the North Central Division stations of Store Street, Mountjoy, the Bridewell and Fitzgibbon Street between May and September 2003. Of the 214 arrestees, 167 were male. Only 14 (6.5%) of these arrests were made under the Misuse of Drugs Act (MDA) 1977.

The take-up rate for the scheme is reported as ‘quite low’, with only a small number of individuals referred to the health services. The report acknowledges that many young arrestees will not see their drug use as problematic but rather as ‘dabbling’ or ‘recreational’ and will therefore not seek help. Also, the low number of MDA-related arrests leads the authors to question whether the scheme should be broadened to all juvenile arrestees regardless of their offence within appropriate qualifications.

Data from the NDTRS also suggests a low referral rate of drug users from criminal justice agencies to the health services. Between 2004 and 2006 only a small number of crack users (six) were directed into drug-treatment by the criminal justice system (Table 10.1). It is not possible to determine from the data the proportion of those people who were referred to treatment by the respective criminal justice agencies, the gardaí, the probation service or the courts.

Table 10.1 Number of new cases who lived in Dublin and reported crack cocaine as a problem drug, by source of referral, as reported to the NDTRS, 2004 to 2006

Source of referral	Number	%
Self	10	28.6
Health service	8	22.9
Court or probation services or police	6	17.1
Family and friends	5	14.3
Social services	4	11.4
Other	1	2.9
Not known	1	2.9
Total	35	100.0

10.6 Drug offences and sentencing

In relation to policing drug markets in general, gardaí have referred to the difficulty of securing lengthy sentences for drugs offences. Gardaí report that there is a tendency by the courts to focus on the value of the drug seized rather than on all aspects of an individual case. From a garda perspective, this can be particularly frustrating in cases where a significant amount of resources have been used to secure evidence against a drug dealer and that person then receives what gardaí perceive to be a minimum sentence, based only on the value of the drug (GN DU, personal communication, 19 May 2006). In relation to crack dealing, the in-depth interviews reveal that many crack dealers, non-Irish nationals in particular, carry a limited amount with them to exchanges with buyers:

And one of them it's like a closed-up house but it's being used as a crack house you know. Like the police have been up to it a number of times. Put the door in to try and catch people selling stuff and that. A couple of times I think they got a little bit out of it. But they never really got much because the coloured guy was cute, you know what I mean? There was not a lot on him. He hides it and he would get a phone call and he'd know exactly how many to bring.

north-inner city, current crack user (October 2007)

10.7 Key findings

- Despite receiving targeted attention from An Garda Síochána, a north-inner city location remains the primary crack market in Dublin. Crack users reported a number of risk-management strategies employed by dealers.
- A number of challenges face effective supply control measures, such as sophisticated importation strategies for powder cocaine, the use of mobile phones and the development of crack houses, which have made street-market activity less visible.

- Participants reported that, in response to increased surveillance from gardaí, dealers were carrying small amounts of crack to exchanges with users; depositing the drug in a hidden area for users to collect (instead of making an exchange); sending potential buyers to different areas of the city rather than making an exchange in the established city-centre market; and refusing to deal to unknown clients.
- Drug-distribution systems adapt quickly, so that drug suppliers who have been arrested are quickly replaced. For example, Operation Clean Street was regarded as a success from a law-enforcement point of view, leading to over 1,100 individual convictions for supply of heroin. However, the success of Operation Clean Street raised the issue of the so-called 'Water Bed Effect' whereby drug activity was displaced to other locations around the city.
- There is growing evidence that partnership working between all stakeholders, including law-enforcement agencies, accommodation and treatment services and local communities, offers the most sustainable method of responding to street-level drug markets.
- Law enforcement can concentrate its effects in specific locations at particular times and, consequently, it is uniquely placed to prevent or disrupt emerging drug markets.
- Limited sources of crack supply in Dublin may have contributed to the stable high price of crack relative to other drugs.
- The price of crack may be a key factor in any potential escalation in its use. Demand is often inelastic for problematic drug users, relative to moderate or recreational users, and increased prices may simply lead them to engage in greater levels of crime in order to pay the higher prices. However, this study found some evidence that the high price of crack does deter use among individuals who are not willing to engage in criminal activity.
- Effective intervention strategies may be those which combine attempts to disrupt local markets, thus rendering them less predictable to both buyers and sellers, with attempts to divert drug offenders into treatment services.
- A report on a pilot arrest referral scheme in Dublin's north-inner city raised a number of questions about the efficacy of the model being applied because the take up for the scheme was quite low. Data from the NDTRS also suggest a low rate of referral of crack users from criminal justice agencies to the health services.

Part 5

Towards a crack cocaine strategy

11 Discussion and research implications

11.0 Overview

The purpose of this report is to help the ISCCSG and other decision makers and stakeholders to develop an evidence-based crack cocaine strategy. This section considers some of the issues arising from the research which a new strategy could address.

11.1 Improving the evidence base relating to crack cocaine – monitoring and further research

It is clear that the precise extent of the crack cocaine problem is not known currently. While accurately reporting a hidden activity (which is part of an illicit activity) is always going to be difficult if not impossible, there are a number of inadequacies in our current data-collection and reporting systems that could be improved upon. This research has emphasised the general importance of continuously monitoring drug trends.

A drug-trend monitoring system could be of major benefit in terms of providing accurate data on trends in drug use and the consequences of these trends. A multi-source information system could draw on information from both new systems and existing systems such as the National Drug Treatment Reporting System, the National Drug Related Deaths Index (NDRDI), the Garda Síochána information technology system Police Using Leading Systems Effectively (PULSE), the Central Statistics Office (CSO), the General Mortality Register (GMR), and the Hospital In-patient data system (HIPE). The new system would feature a method of recording drug seizures by both Customs Drug Law Enforcement and An Garda Síochána, data on the type and purity of substances tested by the Forensic Science Laboratory and data on drug prices. In addition, it would include a harm-reduction information system which would record data on the emergence of new drugs, new ways of using existing drugs, the re-emergence of old drugs, and the incidence of and consequences of drug and alcohol use-related attendances at hospital accident and emergency departments.

It is clear from the study that existing data systems could be improved upon in order to provide a more accurate picture of the extent of crack cocaine use and service providers' responses to its use. Specific issues highlighted in this study include:

- Service providers could ask cocaine users to specify the type of cocaine used and how they use it, so that clients' care plans can address the issue of crack use and so that the NDTRS can obtain a more complete record of cocaine use in Ireland.

- An Garda Síochána could provide more information in PULSE to enhance our understanding of cases where crack cocaine is involved in drug seizures.
- As the study reveals, many users do not report their crack use to treatment services for fear of adverse consequences. In drug treatment centres, policies/ procedures could be introduced to provide clients with reassurances that might help to counter their fears of receiving sanctions (or some other form of punitive response) as a result of revealing information about behaviours related to their drug problem.
- Special methods, such as 'capture-recapture', are needed in order to estimate the true number of crack cocaine users in Ireland. Currently, however, we do not have the appropriate reporting procedures and data to facilitate such methods.
- The improvement of data on the numbers of people who are diverted into treatment from the criminal justice system could assist in developing the capacity of the various agencies of the criminal justice system in this respect. Data from the NDTRS suggests a low referral rate of drug users from criminal justice agencies to the health services. It is not possible to determine from the data the proportion of those people who were referred to treatment by the respective criminal justice agencies, the gardaí, the probation service or the courts. The improvement of data on the numbers of people who are diverted to treatment from the criminal justice system could assist in developing the capacity of the various agencies of the criminal justice system to link into health services and harm reduction initiatives thus enhancing partnership working in this respect.
- There are also no routine data sources to record the physical and mental health consequences of crack use. As many crack users will already have suffered previous ill effects of opiate use, there is a need for continuous monitoring and care provision for this group.
- The involvement of young people in the illicit drug market needs to be investigated.
- Research into the involvement in the illicit drug trade of non-Irish nationals as users, dealers, couriers etc. needs further examination.
- The issue of court sentencing in drug cases and drug-related cases needs to be explored in more detail.

11.2 Responding to crack markets and crack-related crime

Although the city-centre location remains a key market for crack cocaine, all of the indicators used in this study point to a gradual spread of crack use throughout all Local Drugs Task Force areas in the Dublin region. A number of factors may account for the emergence and increased availability of crack use. These include the increased availability of cocaine, and the involvement in the Irish drug market of non-Irish nationals who possibly have access to cocaine supply routes in West Africa and who also have the expertise in preparing crack cocaine. In addition, there is increased demand for crack from opiate users, some of whom may have previously used crack cocaine in the UK. This study provides evidence that Irish nationals have acquired the skills to prepare crack cocaine. However, the stigma associated with crack cocaine use, coupled with its high price, appear to act as disincentives to growth in the spread of its use. Given the demand for illicit drugs, and given the challenges faced by law enforcement agencies in policing a largely hidden trade, reducing the supply and availability of illicit drugs remains a difficult objective.

There needs to be debate about the overall objective of law enforcement in this area. The relationship between supply reduction, demand reduction and harm reduction needs to be further conceptualised. Given the establishment of joint policing committees and local policing fora under the terms of the Garda Síochána Act, 2005 and the National Drugs Strategy, the development of partnership-based approaches to crack markets and crack-related crime can be progressed. A number of specific issues arise from this study:

- As drug markets consolidate over time, the challenges faced by law-enforcement agencies also intensify. However, it is argued in the international literature that law - enforcement agencies could play an important role in intervening at the early stage of a new market. For example, intensive policing and disruption of open markets and so-called crack houses is an achievable goal. However, tackling the crack houses problem would require the gardaí, local authorities, private landlords and social services to work in collaboration with each other.
- Evidence from in-depth interviews with crack users suggests that dealers are targeting people in the vicinity of drug-treatment clinics. The policing of this activity is a sensitive issue because the presence of gardaí could deter drug users from accessing such clinics. The need for an effective partnership response to address this problem is highlighted, as is the need for treatment services to report dealing activity in the vicinity of clinics, and the need for gardaí to respond quickly but in such a way that is sensitive to the importance of retaining users in treatment. Drug dealing in such locations can be extremely detrimental to treatment approaches.

- Females involved in the sex trade are a particularly problematic group. There is evidence of an increase in the number of women entering prostitution for the first time as a consequence of their crack use. Female users appear to develop the most chaotic crack addiction and are thus a particularly vulnerable group. The need for an urgent outreach response is heightened by the possible childcare issues associated with such users.
- The goal of law enforcement could be more broadly conceived, with, for example, greater emphasis placed on the importance of diverting into treatment those offenders whose offence is connected with drug use. There is a need to improve our understanding of both the numbers of people in this category and the numbers of people who are diverted into treatment from all sections of the criminal justice system: gardaí, probation, prosecution, courts and the prison service. The involvement of young people in crack dealing and crack use is an issue which requires further attention.
- With regard to the impact of crack use on the broader family and community, one important issue which has been identified in this study is how the high cost of crack can lead to the diversion of finances from childcare to crack use, and how it can also lead to engagement in prostitution, homelessness, and the intimidation of crack users and their family members by crack dealers over debt collection. The issue of how debt affects users, parents and other family members is a complex one, and needs to be addressed.
- There is an apparent association between crack use and increased aggression. What remains unclear however is the association between crack use and violence – be it individual violence by users or violence associated with the illicit market.
- Crack users appear to be dealing in prescribed substances which are being obtained from pharmacies and/or general practitioners.

It must also be stated that any attempt to develop a sustainable response to crack-related crime must acknowledge the complexity of the relationship between drug use, crime and the underlying social factors which contribute to both. Irish research has consistently revealed that underlying social factors – such as educational disadvantage, poverty and inequality – contribute both to problematic drug use and to criminal behaviour. The findings of this study suggest that the typical crack user is opiate or methadone dependent with a problematic history of drug misuse, and is likely to share many of these social characteristics. This poses a significant challenge to policy makers as it suggests that drug-related crime strategies must move beyond the individual and address the environmental context in which both drug use and crime occur in order to be more effective.

11.3 Reducing the harm that crack cocaine causes both to individuals and communities

The importance of attracting crack users into treatment, and retaining them in treatment, is highlighted in this study. Service providers need to make allowances for the chaotic lifestyles of typical crack users when they are managing clients who are in the initial stages of treatment. The issue of under-reporting of crack use (due to users' fear of sanctions or fears that they may lose access to their children) needs to be addressed. The absence of treatment provision in some services was highlighted in the study. The perception among crack users that services are concerned only with dispensing methadone to heroin users needs to be addressed. There needs to be further debate about the nature of service provision and whether it should encompass polydrug treatment or whether it should be more tailored to specific drug-type treatment only. Since most crack users are polydrug users, the establishment of stimulant-specific services requires careful consideration. Other issues highlighted in this study include the following:

- Attracting crack users into treatment is an important objective. Users who are undertaking education or training programmes, which require a stable lifestyle, may fear that disclosing their crack use will lead to expulsion from these programmes. This appears to be a counterproductive outcome of policy in this area.
- Services could take further steps to offer support/therapies/information to their clients around the issue of crack use.
- There appears to be a perception among some young people that smoking crack is relatively harmless. Addressing this perception would be an important goal of any education/prevention campaign.
- Another vulnerable group highlighted in this study is homeless crack users. Outreach services should be developed to address the needs of homeless people using crack.
- Despite the introduction of a number of training programmes, it appears that there is a need for further information to be provided to service providers in relation to the potential harms associated with crack use, particularly in relation to the routes of administration (i.e. whether crack is smoked or injected). Harm-reduction initiatives need to be informed by evidence as to the methods of crack administration.

11.4 Conclusion

The purpose of this report is to help the ISCCSG and other decision makers and stakeholders to develop an evidence-base for a crack cocaine strategy. This research was conducted using a rapid situation assessment technique recommended by the World Health Organization. The aim of rapid situation assessments is to gather information from multiple data sources within a defined timeframe, using a number of data-collection techniques. The rapid situation assessment has proven particularly suitable in the current context.

The analysis was constrained by the limited amount and quality of data available through the criminal justice system and the quality of the data available through the health system. In addition, the researchers were unable to interview young crack users because such users did not attend any health or social services. Despite the data issues experienced, the main findings of this study are in line with those reported in other countries.

Crack cocaine is a serious and increasing problem for a small number of marginalised drug users in Dublin, many of whom are former opiate users. A high proportion of crack cocaine users are male, homeless, unemployed and do not have formal educational qualifications. The vast majority of cases used more than one drug; opiates (mainly heroin) were the most common drugs used alongside crack. Smoking was the predominant mode of administration of crack. Frequency of use varied from a daily habit to a weekly habit. The most common physical side effects of crack use were breathing problems, heart problems and rapid weight loss and the most common psychological consequences were paranoia, aggressiveness and depression.

Despite targeted Garda operations in 2005/2006, the north-inner city remains the primary crack market in Dublin. According to the data available, crack has been available since late 2006 in other areas of Dublin. Findings indicate that the crack markets currently operating in Dublin are closed markets, that is, dealers do not sell drugs to strangers, exchanges are normally arranged using a mobile phone, and users are directed to specific meeting points outside the inner city for an exchange. Users reported that dealers of West African origin prepared higher quality crack. The price of crack is relatively stable and uniform at €50 for a thumbnail size 'rock'. Dealers use a number of methods to market crack, including selling it in combination with other drugs, targeting drug users outside methadone clinics, and offering heroin users crack instead of heroin.

Shoplifting, burglary and robbery were reported as common means for users to sustain their crack cocaine habit. Among women, an increase in the numbers returning to or beginning sex work was observed by service providers. A small number of users reported dealing prescription drugs. A number of service providers and users reported a rise in the number of aggressive and violent incidents in their localities involving assaults, gangland violence and fatal shootings.

Internationally, the most successful approaches to reducing or ceasing crack use are psychosocial interventions; however, these interventions can only be successful if the user is attracted to and retained in treatment. In order to attract people into a treatment programme, the service provider needs to deal with the immediate needs of the user; in the medium term the provider must be able to deliver services to increase the user's well-being. Some service providers and crack users argue in favour of separate facilities to address cocaine use. Since most crack users are polydrug users, the establishment of stimulant-specific services require careful consideration. Ireland may need to consider placing outreach and psychosocial treatment at the centre of its addiction services, with the addition of medical interventions as a specialist support for detoxification (from opiates, alcohol and benzodiazepines), methadone maintenance and psychiatric treatment.

The evidence indicates that drug-distribution systems adapt quickly, so that a drug supplier who has been arrested will be quickly replaced. International evidence indicates that effective intervention strategies are those which combine attempts to disrupt local markets, thus rendering them less predictable to both buyers and sellers, with attempts to divert drug offenders into treatment services. There is growing evidence that partnership working between all stakeholders offers the most sustainable method of responding to street-level drug markets. If law enforcement authorities concentrated their resources in specific locations at particular times, emerging drug markets could be disrupted or prevented. Limited sources of crack supply in Dublin may have contributed to the stable high price of crack relative to other drugs. Price increases, where they occur, do not necessarily deter problematic users from using drugs but may encourage an increase in crime in order to pay the higher prices. However, this study found some evidence that the high price of crack does deter use among individuals who are not willing to engage in criminal activity.

References

An Garda Síochána (1996) *Annual report of An Garda Síochána*. Dublin: Stationery Office.

An Garda Síochána (1997) *Annual report of An Garda Síochána*. Dublin: Stationery Office.

An Garda Síochána (2000) *Annual report of An Garda Síochána*. Dublin: Stationery Office.

An Garda Síochána (2001) *Annual report of An Garda Síochána*. Dublin: Stationery Office.

An Garda Síochána (2002) *Annual report of An Garda Síochána*. Dublin: Stationery Office.

An Garda Síochána (2003) *Annual report of An Garda Síochána*. Dublin: Stationery Office.

An Garda Síochána (2004) *Annual report of An Garda Síochána*. Dublin: Stationery Office.

An Garda Síochána (2005) *Annual report of An Garda Síochána*. Dublin: Stationery Office.

An Garda Síochána (2006) *Annual report of An Garda Síochána*. Dublin: Stationery Office.

Bean P (2002) *Drugs and crime*. Devon: Willan Publishing.

Best D, Sidwell C, Gossop M, Harris J and Strang J (2001) Crime and expenditure amongst polydrug misusers seeking treatment. *British Journal of Criminology*, 41(1): 119–26.

Bourgois P (2003a) *In search of respect: selling crack in El Barrio*. Cambridge: Cambridge University Press.

- Bourgois P (2003b) Crack and the political economy of social suffering. *Addiction Research Theory*, 11: 31–7.
- Brain K, Parker H and Bottomely T (1998) *Evolving crack cocaine careers: new users, quitters and long term combination drug users in N.W. England*. London: Home Office.
- Burgess R (2003) *Disrupting Crack Markets: a practice guide*. London: Home Office.
- CARBC (Centre for Addiction Research British Columbia) (2007, December 12) *Shared Crack Pipes May Spread Hepatitis C Virus*. Retrieved 11 March 2008 from <http://communications.uvic.ca/releases/release.php?display=release&id=874>
- Caulkins JP (2007) The need for dynamic drug policy. *Addiction*, 102: 4–7.
- CityWide (2006) *Cocaine in local communities: survey of community drugs projects*. Dublin: CityWide Drugs Crisis Campaign.
- CityWide (2004) *Cocaine in local communities: CityWide follow-up survey*. Dublin: CityWide Drugs Crisis Campaign.
- Connolly J (2002) *Community policing and drugs in Dublin: the north-inner city community policing forum*. Dublin: North-inner city Drugs Task Force.
- Connolly J (2005) *The illicit drug market in Ireland. Overview 2*. Dublin: Health Research Board.
- Connolly J (2006a) *Drugs and crime in Ireland. Overview 3*. Dublin: Health Research Board.
- Connolly J (2006b) *Responding to open drug scenes and drug-related crime and public nuisance – towards a partnership approach*. Strasbourg: Council of Europe/Pompidou Group.
- Cox G, Comiskey C, Kelly P and Cronly J (2006) *ROSIE Findings 1: Summary of 1-year outcomes*. Dublin: National Advisory Committee on Drugs.
- Crampton W (2005) *An evaluation of a cocaine training programme*. Dublin: Merchants Quay Ireland.

Dillon L (2001) *Drug use among prisoners: an exploratory study*. Dublin: Health Research Board.

Drugscope (2005) Cocaine/Crack. Retrieved 9 May 2007 from <http://www.drugscope.org.uk>

EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) (1998) *1998 Annual report on the state of the drugs problem in the European Union*. Luxembourg: Office for Official Publications of the European Communities.

EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) (2005) *Annual report 2005. Selected issues: Alternatives to imprisonment – targeting offending problem drug users in the EU*. Luxembourg: Office for Official Publications of the European Communities.

EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) (2006) *Drug availability and drug markets: prices and purity information* [Electronic version]. EMCDDA statistical bulletin. Retrieved May 16 2008 from <http://stats06.emcdda.europa.eu/en/page049-en.html>

EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) (2007a) *Cocaine and crack cocaine: a growing public health issue*. Luxembourg: Office for Official Publications of the European Communities.

EMCDDA (European Monitoring Centre for Drug and Drug Addiction) (2007b) *Cocaine use in Europe: implications for service delivery. Drugs in focus 17*. Luxembourg: Office for Official Publications of the European Communities.

EORG (European Opinion Research Group) (2003) *Public safety, exposure to drug-related problems and crime: public opinion survey*. Brussels: European Commission.

Fischer B and Coghlan M (2007) Crack use in North American cities: the neglected 'epidemic'. *Addiction*, 102(9): 1340–1.

Fitch C and Stimson GV (2003) *An international review of rapid assessments conducted on drug use: a report from the WHO drug injection study, phase II*. Geneva: World Health Organization.

Fountain J (2006) *An overview of the nature and extent of illicit drug use amongst the Traveller Community: an exploratory study*. Dublin: Stationery Office.

- Furey M and Browne C (2004) *Opiate use and related criminal activity in Ireland 2000 and 2001*. Research report No 4/03. Templemore: An Garda Síochána Research Unit.
- GLADA (Greater London Alcohol and Drug Alliance) (2004a) *An evidence base for the London crack cocaine strategy*. London: Greater London Authority.
- GLADA (Greater London Alcohol and Drug Alliance) (2004b) *Community-led innovation in addressing the problems caused by crack cocaine in London*. London: Greater London Authority.
- GLADA (Greater London Alcohol and Drug Alliance) (2004c) *The GLADA crack cocaine strategy 2005–2008*. London: Greater London Authority.
- Goldstein PJ (1985) The drugs/violence nexus: a tripartite conceptual framework. *Journal of Drug Issues*, 15(4): 493–506.
- Goodbody Economic Consultants (2006) *Evaluation of the pilot cocaine project in Tallaght*. Dublin: Department of Community, Rural and Gaeltacht Affairs.
- Goodchild S (2005, 15 May) Dramatic fall in crack price linked to sharp rise in addicts. *The Independent*. Retrieved 16 December 2007 from www.independent.co.uk
- Gossop M, Marsden J, Stewart D and Kidd T (2002) Changes in use of crack cocaine after drug misuse treatment: 4–5 year follow-up results from the National Treatment Outcome Research Study (NTORS). *Drug and Alcohol Dependence*, 66(1): 21–8.
- Gregory T (2006, 2 February) *Parliamentary Debates Dáil Eireann Official Report: unrevised*. Vol. 613, col. 3719. Available at www.oireachtas-debates.gov.ie
- Hannon F, Kelleher C and Friel S (2000) *General healthcare study of the Irish prison population*. Dublin: Stationery Office.
- Harocopos A, Dennis D, Turnbull PJ, Parsons J and Hough M (2003) *On the rocks: a follow-up study of crack cocaine users in London*. London: South Bank University.
- Home Office (2002) *Tackling crack: a national plan*. London: Home Office.
- Home Office (2003) *Crack cocaine in London. Qualitative research focusing on Brent, Camden, Lambeth and Westminster*. Retrieved 17 April 2007 from <http://www.drugs.gov.uk/publication-search/dpas/crackinlondon>

Hough M, Mc Sweeney T and Turnbull P (2000) *Drugs and crime: what are the links? A review prepared for DrugScope's submission to the Home Affairs Select Committee*. London: DrugScope.

Hough M and Natarajan M (2000) Introduction: illegal drug markets, research and policy. In Natarajan M and Hough M (eds) *Illegal drug markets: from research to prevention policy*. Monsey New York: Criminal Justice Press. 1–19.

INCB (International Narcotics Control Board) (2004) *Report 2003*. New York: United Nations Publications.

Jeal N and Salsbury C (2007) Health needs and service use of parlour-based prostitutes compared with street-based prostitutes: a cross-sectional survey. *British Journal of Obstetrics and Gynaecology*, 114(7): 875–81.

Johnson BD, Dunlap E and Tourigny S (2000) Crack distribution and abuse in New York. In Natarajan M and Hough M (eds) *Illegal drug markets: from research to prevention policy*. Monsey, New York: Criminal Justice Press. 19–57.

Keogh E (1997) *Illicit drug use and related criminal activity in the Dublin Metropolitan Area*. Dublin: An Garda Síochána.

Kleiman MAR (1993) Enforcement swamping: a positive feedback mechanism in rates of illicit activity. *Math Comp Model*, 17: 65–75.

Lankenau S, Clatts M, Goldsant L and Welle D (2004) Crack cocaine injection practices and HIV risk: findings from New York and Bridgeport. *Journal of Drug Issues*, 34(2): 319–32.

Lawless M and Corr C (2005) *Drug use among the homeless in Ireland*. Dublin: Stationery Office.

Lenke L and Olsson B (1998) *Heroin seizures as an indicator of variation in market situations: drugs availability and heroin use in Europe*. Strasbourg: Council of Europe.

Levin JD, Culkin J and Perrotto RS (2001) *Introduction to chemical dependency counselling*. Northvale, New Jersey: Jason Aronson.

Long J, and Keenan E (2007) The evidence base for treatment of problem cocaine use. *Drugnet Ireland* 21: 16

Loughran H and McCann ME (2006) *A community drugs study: developing community indicators for problem drug use*. Dublin: National Advisory Committee on Drugs.

Lupton R, Wilson A, May T, Warburton H and Turnbull PJ (2002) *A rock and a hard place: drug markets in deprived neighbourhoods*. London: Home Office.

May T, Edmunds M and Hough M (1999) *Street business: the links between sex and drug markets*. London: Home Office PRCU.

May T and Hough M (2001) Illegal dealings: the impact of low-level police enforcement on drug markets. *European Journal on Criminal Policy and Research*, 9(2): 137–62.

May T and Hough M (2004) Drug markets and distribution systems. *Addiction Research & Theory*, 12(6):549–63.

Mazerolle L, Soole DW and Rombouts S (2006) Street-level drug law enforcement: a meta-analytical review. *Journal of Experimental Criminology*, 2: 409–35.

Morgan JP and Zimmer L (1997) The social pharmacology of smokeable cocaine: not all it's cracked up to be. In Reinerman and Levine (eds) *Crack in America: demon drugs and social justice*. Berkeley: University of California Press. 131–70.

NACD (National Advisory Committee on Drugs) (2007a) *Drug trend monitoring system pilot report*. Dublin: National Advisory Committee on Drugs.

NACD (National Advisory Committee on Drugs) (2007b) *An overview of cocaine use in Ireland: II*. Dublin: National Advisory Committee on Drugs.

NACD and DAIRU (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit) (2008) *Drug use in Ireland and Northern Ireland: results by regional task force area from the 2006/2007 drug prevalence survey*. Bulletin 2 Dublin: National Advisory Committee on Drugs.

NIDA (National Institute on Drug Abuse) (2004) *Cocaine abuse and addiction*. Research Report Series [Electronic Version]. NIH Publication No. 99-4342, Printed May 1999, Revised November 2004. Retrieved from <http://www.nida.nih.gov/ResearchReports/Cocaine/Cocaine.html>

North-inner city Drugs Task Force (2005) *Changing track: a study informing a juvenile arrest referral pilot in the North-inner city*. Dublin: North-inner city Drugs Task Force.

O'Keefe C (2005, 8 March) Crack cocaine gang raided. *Irish Examiner*. Retrieved 6 April from www.irishtimes.com

O'Mahony P (1997) *Mountjoy prisoners: a sociological and criminological profile*. Dublin: Department of Justice.

O'Neill M and O'Connor A (1999) *Drug using women working in prostitution*. Dublin: Women's Health Project, Eastern Health Board and the European Intervention Project, AIDS Prevention for Prostitutes.

O'Regan M (2006, 3 February) McDowell promises tough line on crack cocaine dealers. *Irish Times*. Retrieved 6 April 2006 from www.irishtimes.com

Parker H and Bottomley T (1996) *Crack cocaine and drugs-crime careers*. London: Home Office.

Pearson G and Hobbs D (2001) *Middle market drug distribution*. Home Office Research Study No. 227. London: Home Office.

Pudney S (2002) *The road to ruin? Sequences of initiation into drug use and offending by young people in Britain*. London: Home Office.

Raggett E, Lakes R, Murphy E and Delaney G (2003) 'Has crack cocaine hit Irish streets'. *The Irish Scientist Yearbook 2003*. Retrieved from www.irishscientist.ie

Reinarman C and Levine HG (2004) Crack in the rear-view mirror: deconstructing drug war mythology. *Social Justice*, 31 (1-2): 182-99.

Reinarman C, Waldorf D, Murphy S and Levine H (1997) The contingent call of the pipe: bingeing and addiction among heavy cocaine smokers. In Reinarman C and Levine HG (eds) *Crack in America: demon drugs and social justice*. Berkeley: University of California Press.

Reynolds S, Fanagan, S, Bellerose, D, Long, J (2008) *Trends in treated problem drug use, 2001 to 2006 (647 KB)*. (pdf). Dublin: Health Research Board.

Reuter P, MacCoun R and Murphy (1990) *Money from crime: a study of the economics of drug dealing in Washington, DC*. Santa Monica: Rand.

Robson C (2002) *Real world research: a resource for social scientists and practitioner-researchers*. Oxford: Blackwell.

- San Diego Police Department (1998) *Operation hot pipe, smokey haze and rehab: disrupting an illicit drug market*. San Diego: San Diego Police Department.
- Scottish Executive (2004) *Reducing the impact of local drug markets: a research review* [Electronic version]. Retrieved 16 May 2008 from www.drugmisuse.isdscotland.org
- Sterk C (1999) *Fast lives: women who use crack cocaine*. Philadelphia: Temple University Press.
- Stevens A, Trace M and Taylor DB (2005) *Reducing drug-related crime: an overview of the global evidence*. The Beckley Foundation Drug Policy Programme. Retrieved March 10 2008 from <http://www.beckleyfoundation.org/policy/reports.html>
- Strange J and McGauley A (2004) *Crack use in Sheffield*. London: Turning Point/Sheffield University.
- Terence Higgins Trust (2006) *The sex workers into sexual health (SWISH) project* [Electronic Version]. Retrieved 10 March 2008 from <http://www.renewal.net/Documents/RNET/Case%20Study/SWISHproject.doc>
- Tragler G, Caulkins JP and Feichtinger G (2001) Optimal dynamic allocation of treatment and enforcement in illicit drug control. *Operational Research*, 49: 352–62.
- Turning Point (2005) *The crack report*. London: Turning Point.
- UK Focal Point on Drugs (2007) *UK – New Developments, trends and in-depth information on selected issues. 2007 National Report (2006 data) to the EMCDDA UK*. UK Focal Point on Drugs.
- UNDCP (United Nations Drug Control Programme) (1999) *Drug abuse rapid situation assessments and responses*. Vienna: United Nations Office for Drug Control and Crime Prevention.
- UNODC (United Nations Office on Drugs and Crime) (2005) *2005 World drug report. vol. 1: analysis*. New York: United Nations Publications.
- Wagstaff A and Maynard A (1988) *Economic aspects of the illicit drug market and drug enforcement policies in the United Kingdom*. London: Her Majesty's Stationery Office.
- Ward H, Pallearos A, Green A and Day S (2000) Health issues associated with increasing use of crack cocaine among female sex workers in London. *Sexually Transmitted Infections*, 76: 292–3.

Warner E (1993) Cocaine abuse. *Annals of Internal Medicine*, 119(3): 226–35.

White HR and Gorman DM (2000) Dynamics of the drug-crime relationship. In LaFree G (ed.) *Criminal justice 2000: the nature of crime: continuity and change*. Washington: US Department of Justice.

Wilson L and Stevens A (2008) *Understanding drug markets and how to influence them* [Electronic version]. The Beckley Foundation Drug Policy Programme. Retrieved 16 May 2008 from <http://www.beckleyfoundation.org/policy/reports.html>

Wincup E, Buckland G and Bayliss R (2003) *Youth homelessness and substance use: report to the drugs and alcohol research unit*. London: Home Office.

World Health Organization (2002) *The rapid assessment and response guide on psychoactive substance use and sexual risk behaviour*. Geneva: World Health Organization.

Statutes

Misuse of Drugs Act 1977 (Controlled Drugs) (Declaration) Order 2006. Number 55 of 2006. Dublin: Stationery Office.

Misuse of Drugs Act 1988. Number 18 of 1984. Dublin: Stationery Office.

Misuse of Drugs Regulations, 1988. S.I. No. 328 of 1988. Dublin: Stationery Office.

Appendix A:

An evidence base for treating cocaine and crack cocaine

Source: Long J and Keenan E (2007) The evidence base for treatment of problem cocaine use. *Drugnet Ireland*, Spring Issue 21: 16

The following is an extract taken from an annotated bibliography of studies evaluating the effectiveness of a variety of treatment interventions for problem cocaine use.

Organisation

The four-tier model of service delivery, which offers clients the least intensive intervention appropriate to their need has been adopted as the framework for the future delivery of alcohol and drug services in Ireland; this approach should be considered in the development of any crack treatment strategy.

Evidence base for crack treatment

This section presents details a summary of the evidence-base for the treatment of cocaine either powder or crack. Many of the studies reviewed include polydrug users. Where possible, the evidence is based on systematic reviews (Greenhalgh 1997). A systematic review is an overview of primary studies that used explicit and reproducible methods. The treatment options examined include psychosocial approaches, complementary therapies and medications.

The ideal combination of interventions selected would seek to attract persons into treatment, retain them in treatment, reduce or cease their cocaine and other drugs use, and prevent relapse.

As with all drugs except opiates, the therapeutic management of people addicted to crack or powder cocaine is based on abstinence from cocaine use. In the initial period following cessation, the person being treated may experience an intense craving for cocaine, and symptoms such as depression, fatigue, irritability, anorexia and sleep disturbance. The past decade has seen a sustained search for an effective treatment for the management of cocaine dependence.

The indicators used to measure the success of treatment for problem cocaine use used in the evidence presented are: the absence of drug metabolites in the urine during and following treatment; retention in and completion of treatment interventions; and attendance at aftercare.

Attracting and retaining clients

The Drug Treatment Agency (DTA) in the UK emphasises a number of key practices which improve the success of cocaine treatment. According to the DTA, once the initial contact with a treatment service is made, rapid intake, proactive reminders, and practical help with attendance improve treatment uptake rates. Once cocaine users start treatment, they tend to stay longer and respond better if they feel that their concerns are being positively addressed and that their key worker is empathic and understanding. This indicates the crucial role that key workers play in assessing, motivating and retaining clients. The provision of complementary therapies is important to attract clients into treatment, enhance their well-being and retain them in treatment. A similar approach to that in the UKL has been tried with intranasal cocaine users in Tallaght and was deemed very successful.

The Department of Community, Rural and Gaeltacht Affairs funded the Tallaght community-based project involving St Dominic's Community Response Project and Killinarden's Community Addiction Response Programme for problematic intranasal cocaine users (Goodbody Economic Consultants 2006). The interventions planned were advertising service availability, project meetings, relationship building, individual care plans, individual counselling, and holistic therapies. The project commenced in February 2005. The project employed six staff members on a part-time basis. The service was provided through two evening sessions and one afternoon session. The cocaine treatment service was promoted through a media campaign and proactive outreach work. The project communicated with cocaine users and concerned persons by telephone and received an average of 20 calls per week. During its first year, 99 cocaine users attended the project, of whom 60 (61%) returned more than once. The uptake of complementary treatments, such as acupuncture and Indian head massage, was high. A further 60 people were assisted by the outreach worker. Seven clients were interviewed at the end of the project, of whom four were abstinent from all drugs and two said that their suicidal thoughts had ceased. According to the evaluators, Goodbody Economic Consultants, the project was effective and very good value for money.

Brief intervention

Bernstein and colleagues (2005) conducted a randomised control trial to determine whether brief motivational counselling was more effective than written information in reducing cocaine use among clients attending an outpatient clinic in Boston. Six months following intervention, they found marginally higher rates of abstinence among those who attended brief motivational counselling than among those who received written information. For those reporting both cocaine and opiate use, the abstinence rates were 22% among those who were given brief motivational counselling, compared to 17% among those who received information; among cocaine users, the corresponding abstinence rates were 17% and 13% respectively. It is interesting to

note that providing information on cocaine itself and its associated treatment options did encourage some respondents to seek help. Indeed, despite the title of this paper, the differences in abstinence rates for the two interventions were neither clinically nor statistically significant. The data presented in this paper indicate that information or brief intervention would be effective if provided at accident and emergency, harm reduction and opiate treatment services. The information brief or leaflet should cover the dangers of cocaine use, the symptoms of dependence and the treatment services available.

Cognitive behavioural therapy and counselling

Cognitive behavioural therapy is a system of psychotherapy which attempts to reduce excessive emotional reactions and self-defeating behaviours by modifying underlying erroneous thinking and maladaptive beliefs. According to experts in this area, the cognitive approach, when applied to substance abuse, helps individuals deal with the problems leading to emotional distress and gain a better perspective on their reliance on drugs. Specific cognitive strategies are said to help individuals establish stronger internal controls and reduce their urges to take drugs. In addition, cognitive therapy can help patients to combat depression, anxiety or anger, which increase addictive behaviours.

Since there were no systematic reviews in the Cochrane Library that examined the evidence of effectiveness of psychotherapeutic interventions (such as cognitive behavioural therapy) in the treatment of cocaine dependence, some individual studies were reviewed for the purposes of this article.

Crits-Christoph and colleagues (1999) examined combinations of psychosocial treatments for cocaine dependence. They compared four different treatments – cognitive therapy, psychodynamic therapy, individual drug counselling, and group drug counselling alone. The first three treatments mentioned included group drug counselling along with the specific individual therapy. Treatments were intensive and provided over a six-month period. The clients were followed up at six and at twelve months. The authors found that, when compared to the two forms of psychotherapy and to group drug counselling alone, individual drug counselling plus group work showed the greatest improvement in the number of days the clients did not use cocaine over a one-month period. The authors were surprised by this finding because in 1991 Carroll and colleagues reported that relapse-prevention therapy (a form of cognitive behaviour therapy) was more effective than interpersonal psychotherapy, and had higher abstinence and recovery rates. In 1994, Higgins and colleagues reported that relapse prevention therapy with the addition of incentives was more effective than relapse prevention therapy alone. The clients who received incentives were more likely to complete their treatment and had a longer duration of cocaine-negative urines.

Crits-Christoph and colleagues (1999) reviewed the evidence from the earlier studies mentioned and pointed out that the counsellors selected to participate in their study followed a detailed manual and provided intensive counselling with a strong focus on drug abstinence. They reported that psychotherapy was more effective in clients with psychiatric symptoms, and pointed out that their own study involved a relatively small number of such clients. In a follow-up analysis of the same cohort, (2001) the authors noted that there was no difference between the four types of treatment in other important measures of success, such as psychiatric symptoms, alcohol use and employment rates, nor in relation to interpersonal, social and family issues.

The evidence presented in these studies indicate that basic criteria for assigning clients to either cognitive therapy or individual counselling must be developed and circulated. In addition, extensive training and detailed manuals which increase the effectiveness of therapy and counselling are required (examples on the US National Institute on Drug Abuse website: www.nida.nih.gov). The provision of incentives may be considered for particular client groups if and when necessary.

Therapeutic communities

Therapeutic communities are a popular treatment for the rehabilitation of drug users in the USA and Europe. In a review of seven studies, Smith and colleagues (2006) examined the effectiveness of therapeutic communities compared to other treatments for substance misusers, and investigated whether their effectiveness was modified by client or treatment characteristics. Differences between the studies reviewed precluded any pooling of data; results were summarised for each trial individually. The authors concluded that there was little evidence that therapeutic communities offered significant benefits in comparison with other residential treatments, or that one type of therapeutic community was better than another. There was some evidence of reduced re-offending among prisoners who had participated in therapeutic communities while in prison. However, methodological limitations may have introduced bias to the studies, and firm conclusions could not be drawn due to the limitations of the existing evidence.

Acupuncture

Auricular acupuncture (insertion of acupuncture devices into a number of specific points in the outer ear) is a widely used treatment for cocaine dependence. Gates and colleagues (2006) assessed its effectiveness in a review of seven study trials, all of which were of low methodological quality. The review found no evidence that auricular acupuncture was effective in the treatment of cocaine dependence. High-quality randomised trials of auricular acupuncture may be justified.

Medications

A number of studies have concentrated on finding a medicine to alleviate depression associated with cocaine use and to reduce cocaine craving. Lima and colleagues (2003) completed a systematic review of 18 randomised control trials on the use of **antidepressants** in treating cocaine dependence. The authors found that trials had not shown that antidepressants helped reduce cocaine dependence, although this might have been partly because many people stopped using the antidepressants too early. More people might have benefited if they had continued to use antidepressants for an appropriate period of time. The findings and recommendations were similar for cocaine users who were also dependent on heroin or were on methadone programmes. Individuals attending treatment programmes may benefit from supervised consumption of anti-depressants and this approach should be tested using an appropriate research method.

Because chronic use of cocaine decreases dopamine concentrations in the brain, it was thought that pharmacological treatment that controlled dopamine levels could theoretically reduce these symptoms and contribute to a more successful therapeutic approach. Soares and colleagues (2003) evaluated the efficacy and acceptability of **dopamine agonists** for treating cocaine dependence through a systematic review of 17 studies. The authors reported that dopamine agonists had been used for reducing the symptoms that patients experienced during the initial period of abstinence from cocaine. This review of trials found that the evidence of success was not adequate to support the use of dopamine agonists as a treatment for cocaine dependence.

The anti-convulsant **carbamazepine** (a tricyclic medication that is widely used to treat a variety of neurological and psychiatric disorders) has been used for treatment of cocaine dependence. Lima-Reisser and colleagues (2002) examined whether carbamazepine was effective in the treatment of cocaine dependence through a systematic review of five studies. The review of trials found that carbamazepine had not been shown to help reduce cocaine dependence. The drop-out rate from treatment was high, adverse effects were common, and there was no significant fall in the participants' cocaine use.

Silva de Lima and colleagues (2002) reviewed the efficacy of pharmacotherapy in treating cocaine dependence. The drug treatments included in the trials were grouped into the following categories: antidepressants, carbamazepine, dopamine agonists, and miscellaneous other drugs. The miscellaneous treatments included naltrexone, mazindol, lithium, disulfiram, phenytoin, nimodipine, lithium carbonate, NeuRecover-SA and risperidone. The effects of these drugs were compared with each other or with a placebo. Seven studies were included in the review. The authors concluded that there was no current evidence to support the clinical use of most of these drugs, including **disulfiram**, in the treatment of cocaine dependence.

Vaccine

Hall and Carter (2004) state that 'a **cocaine vaccine** is a promising immunotherapeutic approach to treating **cocaine** dependence which induces the immune system to form antibodies that prevent **cocaine** from crossing the blood brain barrier to act on receptor sites in the brain. The most promising application of a **cocaine vaccine** is to prevent relapse to dependence in abstinent users who voluntarily enter treatment'. Two published studies examined the use of cocaine vaccine among human populations (Martell *et al.* 2005; Kosten *et al.* 2002). Both studies showed some promising results; however, general availability of a cocaine vaccine is not imminent. This intervention will only be useful for relapse prevention.

- 1 Greenhalgh T (1997) How to read a paper: Papers that summarise other papers (systematic reviews and meta-analyses) *British Medical Journal*, 315: 672–675.
- 2 Lima MS, Reisser Lima AAP, Soares BGO and Farrell M (2003) Antidepressants for cocaine dependence. *Cochrane Database of Systematic Reviews*, Issue 2. Art. No.: CD002950. DOI: 10.1002/14651858.CD002950.
- 3 Soares BGO, Lima MS, Lima Reisser A and Farrell M (2003) Dopamine agonists for cocaine dependence. *Cochrane Database of Systematic Reviews*, Issue 2. Art. No.: CD003352. DOI: 10.1002/14651858.CD003352.
- 4 Lima Reisser A, Lima MS, Soares BGO and Farrell M (2002) Carbamazepine for cocaine dependence. *Cochrane Database of Systematic Reviews*, Issue 2. Art. No.: CD002023. DOI: 10.1002/14651858.CD002023.
- 5 Silva de Lima M, de Oliveira Soares BG, Pereira Reisser AA and Farrell M (2002) Pharmacological treatment of cocaine dependence: a systematic review. *Addiction*, 97(8): 931–949.
- 6 Gates S, Smith LA and Foxcroft DR (2006) Auricular acupuncture for cocaine dependence. *Cochrane Database of Systematic Reviews*, Issue 1. Art. No.: CD005192. DOI: 10.1002/14651858.CD005192.pub2.
- 7 Smith LA, Gates S and Foxcroft D (2006) Therapeutic communities for substance related disorder. *Cochrane Database of Systematic Reviews*, Issue 1. Art. No.: CD005338. DOI: 10.1002/14651858.CD005338.pub2.
- 8 Crits-Christoph P, Siqueland L, Blaine J, Frank A, Luborsky L, Onken LS *et al.* (1999) Psychosocial treatments for cocaine dependence: National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *Archives of General Psychiatry*, 56(6): 493–502.
- 9 Carroll KM, Rounsaville BJ and Gawin FH (1991) A comparative trial of psychotherapies for ambulatory cocaine abusers: relapse prevention and

interpersonal psychotherapy. *American Journal of Drug & Alcohol Abuse*, 17(3): 229–247.

- 10 Higgins ST, Budney AJ, Bickel WK, Foerg FE, Donham R and Badger GJ (1994) Incentives improve outcome in outpatient behavioral treatment of cocaine dependence. *Archives of General Psychiatry*, 51(7): 568–576.
- 11 Crits-Christoph P, Siqueland L, McCalmont E, Weiss RD, Gastfriend DR, Frank A *et al.* (2001) Impact of psychosocial treatments on associated problems of cocaine-dependent patients. *Journal of Consulting and Clinical Psychology*, 69(5): 825–830.
- 12 Bernstein J, Bernstein E, Tassiopoulos K, Heeren T, Levenson S, Hingson R (2005) Brief motivational intervention at a clinic visit reduces cocaine and heroin use. *Drug and Alcohol Dependence*, 77(1): 49–59.
- 13 Hall W and Carter L. (2004) Ethical issues in using a cocaine vaccine to treat and prevent cocaine abuse and dependence. *Journal of Medical Ethics*, 30(4): 337–340.
- 14 Martell BA, Mitchell E, Poling J, Gonsai K and Kosten TR (2005) Vaccine pharmacotherapy for the treatment of cocaine dependence. *Biological Psychiatry*, 58(2):158–64.
- 15 Kosten TR, Rosen M, Bond J, Settles M, Roberts JS, Shields J, Jack L and Fox B (2002) Human therapeutic cocaine vaccine: safety and immunogenicity. *Vaccine*, 20(7–8):1196–1204.

Appendix B:

An evidence base for crack cocaine law enforcement

The following is an extract taken from an annotated bibliography of studies evaluating the effectiveness of a variety of police-led drug law enforcement interventions aimed at reducing drug problems.

Source: Mazerolle L, Soole D and Rombouts S (2005) *Monograph number 5: drug law enforcement: the evidence*. DPMP Monograph series. Fitzroy: Turning Point Alcohol and Drug Centre: Australia

Jurisdiction	Intervention/Description	Main Findings/Effectiveness
Vancouver, Canada 2003	Crackdown Large-scale enforcement operation to reduce dealing and use in downtown's Eastside. Saturation patrol with arrests.	No significant impact on changes in levels of drug use, frequency of drug use, or drug price. Significant shift in locations where drugs were used,, significant reduction in the willingness of users to inject at safe injection sites. Evidence of displacement of drug activity to more private locations
10 London boroughs, UK 2000	Crackdown Concentrated, time-limited and intensive police operations targeting street-level and drug house dealers for arrest and drug seizure.	Many arrests and a large amount of drugs seized. However, no significant overall changes in availability, purity or price of heroin, cocaine or cannabis. No significant effects on crime rates. However, local residents did report a reduction in fear of crime.
Western Chicago, Illinois 1999	Diversion <i>Distressed Neighbourhoods Initiative</i> Multi phase process initially involving saturation patrolling followed by continued high visibility patrolling of problem areas with the support of public and private agencies Crime prevention is implemented through environmental design techniques. Public and private agencies promote investment in the community	Virtual elimination of the drug market and all associated drug activity. Reduction in the percentage of drug related incidents (from 50% to 22%), as well as dramatic decreases in reported crime (90%) and calls for service (72%).

Jurisdiction	Intervention/Description	Main Findings/Effectiveness
Kings Cross London, UK 1999	Arrest Referral <i>Capital Care Project (CCP)</i> Program targets drug abusing sex workers. Offenders are referred to a number of treatment services and agencies by a Needs Assessment Worker (NAW). Aim is to reduce drug use and related offending.	Intervention had very little effect on heroin and crack use rates. Frequency of daily use, average amount used, daily expenditure and frequency of injecting and smoking were unaffected as a result of the intervention.
North- West Washington DC 1997	<i>Diversion Levis Street Project</i> Set up observation posts, conducted undercover buys, reverse stings, aggressive patrol (with a zero-tolerance approach), traffic stops and vehicle checks, periodic K9 (sniffer dogs) sweeps of the area and used other investigative techniques to gain arrest and search warrants. Crime prevention through environmental design techniques such as foliage trimming, removal of rubbish and abandoned vehicles, inspections of businesses and properties and changing the street to a one-way road	Observed drug dealing decreased. Residents reported improvements in quality of life, increased feelings of safety, more satisfaction with the neighbourhood and improved perceptions of the police.
Spokane, Washington 1996	Drug Nuisance Abatement & Civil Remedies <i>West First Project</i> Civil remedies initiative involving code enforcement, cooperation with the liquor board, prosecution of gang members under organised crime statutes and enhancement of correctional supervision of offenders living in the project area. Crime prevention through environmental design techniques also employed to create defensible space.	Violent crime reduced by 75%. Calls for service and officer initiated activity decreased by 35%. Observations of community revitalisation and an elimination of criminal activity which was replaced with legitimate business activity.

Jurisdiction	Intervention/Description	Main Findings/Effectiveness
San Diego, California 1996	<p>Diversion</p> <p>A Three phase response:</p> <p>1) Operation Hot Pipe-Increased patrol and marketing of anti-drug tactics to make target area undesirable for drug users and dealers.</p> <p>2) Operation Smokey Haze - series of reverse stings, sweeps, and leaks (some honest and some fabricated) to users and dealers of police operations to be employed with the aim of confusing users/dealers and continuing to make the target area an undesirable place for them to be.</p> <p>3) Operation Rehab - local marketing firm volunteered to work with the police to help local businesses to promote the area, fliers providing info on drug treatment services were distributed to users/dealers</p>	<p>Many of the dealers were arrested and incarcerated which resulted in the market being destabilised. Reduction in robberies.</p> <p>Majority of the local businesses (83%) indicated the intervention had a positive effect and reported a 36% increase in business.</p> <p>Users reported an increased difficulty in purchasing crack on the street.</p>
Santa Barbara, California 1995-1996	<p>Diversion</p> <p><i>Dennis Palmer Elk's Lodge</i></p> <p>Initially engaged in undercover buy-bust operations to suppress dealing at the target location. Second, alcoholic beverage licence of the nightclub was revoked. Finally, drug nuisance abatement processes used to evict the owners from the club and close the property.</p>	<p>Drug activity and associated criminal activity no longer exists at the address. Property owners and businesses have begun to reinvest in the community. Improvements in the trust and confidence local residents and businesses have in the police, as well as quality of life.</p>
Seminole County, Florida 1995	<p>Drug Nuisance Abatement & Civil Remedies</p> <p><i>Lockhart Neighbourhood Project</i></p> <p>Absentee landlord whose property was being used as a crack house sold the property to the neighbouring church who converted the property into a car park. Abatement processes were used to evict the tenants and demolish the crack house.</p>	<p>The drug and crime problems associated with the address eliminated. Quality of life at the intersection where the property was situated improved. Calls for service related to crack sales virtually ceased.</p> <p>Some displacement to nearby areas.</p>

Jurisdiction	Intervention/Description	Main Findings/Effectiveness
Spokane, Washington 1994	Community Policing <i>Project ROAR</i> Community policing initiative aimed at improving quality of life, involving cooperation between the police department, housing authority and residents. Establishment of a local 'Cop Shop', assigning community police officers to the project area, coordination with crime prevention organisations, employment of a resident resource coordinator, physical improvements to the neighbourhood, situational prevention strategies (e.g. target hardening) and assignment of a community corrections officer to the project area	Mixed results – increased arrests and offences across targeted and non targeted areas. However, interviews with residents reveal levels of fear had significantly decreased between 1994 and 1997. Residents also perceived an improvement in the social conditions of the area.
Delray Beach, Florida 1994	Combination <i>Mario's Market Project</i> Crime prevention through environmental design (e.g. additional lighting, repaired fencing, improvements to the general physical appearance of the buildings, removal of rubbish, installation of surveillance cameras etc). These efforts were followed up with drug nuisance abatement processes, where crack houses are issued code violations, problem tenants evicted, dilapidated buildings condemned.	Observed drug and associated criminal activity, calls for service and arrests reduced. Several crack houses torn down and several individuals helped into treatment. Evidence of displacement with many drug dealers were reported to have left the area and moved operations to other cities.
Kansas, Missouri 1991	Raids Suspected crack house raids by police, securing the premises, detaining persons, searching the premises and seizing illegal goods (drugs, weapons, stolen property). Raids were forceful and highly evident to surrounding residents (deterrent).	Positive but modest results point to concerns regarding the cost effectiveness of raids.
Montreal, Canada 1989	Crackdown Single day of intensive policing by over 100 officers at just 26 residential hotspots to target dealing. Raids, buy-busts and arrests.	Significant reduction in property crime. The crackdown appeared to be successful in stopping the emergence of drug markets in the district because it was massive and conducted before the drug markets had a chance to establish themselves.

Jurisdiction	Intervention/Description	Main Findings/Effectiveness
Detroit, Michigan 1989	Crackdown Undercover operations and buy-busts. Indoor and open-air dealing targeted, involved the development of two separate, but complementary, units focused on indoor sales and open-air street markets.	Majority of officers stated that drug dealers adapted their operations to counter the increased risk of arrest. No apparent significant impact.
San Diego, California 1989	Crackdown 100 uniformed officers engaged in high visibility patrol in problem drug areas to combat gang and drug problems. 20-30 plain clothes, undercover officers responding to citizen complaints through the use of informants, controlled buys, buy-bust operations and search warrants. 5 plain clothes undercover officers targeted mid-level crack dealers. The 3 teams also used directed patrol, arresting users and dealers for other offences, traffic stops, surveillance, reverse stings and raids.	Police perceived their efforts to impact on the purity and price of drugs but were less confident their efforts impacted demand or availability. Police records suggested that buy-busts were the most effective strategy in making sales arrests, followed by the execution of search warrants, and observation. Further, patrol/traffic stops were the most effective strategy for making possession arrests, following the execution of search warrants, observation, and buy-busts.

Appendix C:

Recent HRB series publications

HRB Research Series

Tedstone Doherty D, Moran R and Kartalova-O'Doherty Y (2008) *Psychological distress, mental health problems and use of health services: assembling the pieces of support needs for mental health problems in Ireland*. HRB Research Series 5. Dublin: Health Research Board.

Gallagher S, Tedstone Doherty D, Moran R and Kartalova-O'Doherty Y (2008) *Internet use and seeking health information online in Ireland: demographic characteristics and mental health characteristics of users and non-users*. HRB Research Series 4. Dublin: Health Research Board.

Daly A, Tedstone Doherty D and Walsh D (2007) *Re-admissions to Irish psychiatric units and hospitals 2001–2005*. HRB Research Series 3. Dublin: Health Research Board.

HRB Overview Series

Walsh D (2008) *Suicide, attempted suicide and prevention in Ireland and elsewhere*. Overview 7. Dublin: Health Research Board.

Mongan D, Reynolds S, Fanagan S and Long J (2007) *Health-related consequences of problem alcohol use*. Overview 6. Dublin: Health Research Board.

Keane M (2007) *Social reintegration as a response to drug use in Ireland*. Overview 5. Dublin: Health Research Board.

HRB Statistics Series

Daly A, Walsh D and Moran R (2007) *Activities of Irish Psychiatric Units and Hospitals 2006*. HRB Statistics Series 4. Dublin: Health Research Board.

O'Donovan M-A, Doyle A and Craig S (2007) *National Physical and Sensory Disability Database Committee annual report 2007*. HRB Statistics Series 3. Dublin: Health Research Board.

Kelly F, Kelly C and Craig S (2007) *Annual report of the National Intellectual Disability Database Committee 2007*. HRB Statistics Series 2. Dublin: Health Research Board.

HRB Trends Series

Kelly F, Craig S and Kelly C (2008) *Trends in demand for services among children aged 0-5 years with an intellectual disability, 2003 – 2007*. HRB Trends Series 3. Dublin: Health Research Board.

Reynolds S, Fanagan S, Bellerose D and Long J (2008) *Trends in treated problem drug use in Ireland, 2001 to 2006*. HRB Trends Series 2. Dublin: Health Research Board.

Fanagan S, Reynolds S, Mongan D and Long J (2008) *Trends in treated problem alcohol use in Ireland, 2004 to 2006*. HRB Trends Series 1. Dublin: Health Research Board.

